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MICHIGAN MEDICINE

July 1985 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 84, No. 7

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Lawmakers hear liability testimony

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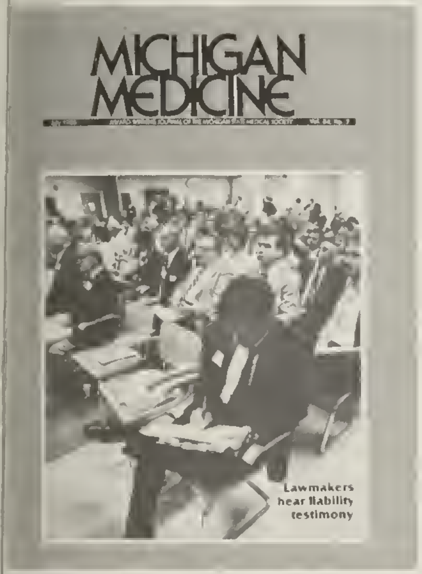

About the cover: About 400 physicians and other health care professionals crowded the June 7 Senate Judiciary Committee hearing on the professional liability problem. MSMS members from around Michigan testified regarding the severity and implications of the situation.

Special Report

378 Physicians' and insurance executives' testimony at a recent Senate Judiciary Committee hearing makes up this month's special report. This varied palette of fact and opinion on the professional liability crisis helps to paint the big picture of the situation in Michigan today: Kevin Clinton; Richard Horsch, MD; Cecil R. Jonas, MD; Silas Norman, Jr., MD; William G. Olsen; Jack Ryan, MD

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In next month's issue of *Michigan Medicine:* The special problems and needs of impaired physicians, and the programs in place to help them, will be our focus next month.

IN MY OPINION

By Marguerite Shearer, MD

We must develop a rational opposition

The proposed insurance rate increases and the concomitant impact on the cost and availability of medical care are current topics of concern to us all. We are told of the increasing size of "awards" of "settlements," the ever increasing payout from the insurers, yet few physicians fully understand the theories and mechanics of the insurance industry.

Like an overt school of mysticism, a movement seeking to achieve a particular goal may feel it has to invoke the higher mysteries of an incomprehensible authority. The attainment of the goal may not count on physicians' intelligence, but on their weaknesses, pretentions and fears. The path may not be one of enlightenment, but of intellectual intimidation. It may not be aimed at a person's understanding, but at his or her inferiority complex.

We are often willing to take the blame, under a barrage of authoritative pronouncements, for our failure to understand. We assume that an insurance commissioner's/professional liability company's theory is scientifically proved and that they alone are able to grasp it; like students anxious to hide their inability, some profess agreement, and the less they understand, the louder they agree.

When we accept blindly the commissioner/company doctrine and edicts, albeit reluctantly and uneasily, we lose our intellectual integrity — condemning ourselves to a chronic fog of apprehension and feeling of lack of control. Contradictory interpretations of financial data will be ascribed to the problem's profundity—"I don't understand it, it's too complex." The doctors believe the company boards know the proof of need for increased rates, the boards believe the actuaries know, and the commissioner or whomever authored the theory may be the only one who knows that no proof exists and that none was offered.

We must develop an intransigent, rational opposition to the current liability situation. Acts and possibilities need to be explored — arbitration, rates, reserving practices, no-fault, capping of liability, realistic statutes of limitations, and many more. It behooves us all to discipline ourselves to acquire the necessary knowledge and understanding of this important factor in our professional lives. Active, critical, and creative thinking is a vital necessity.☐

Doctor Shearer, Dexter family physician, is an MSMS Board member and serves on the Publications Committee.

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Recompression treatment in Kalamazoo

I was distressed to read your article on page 283 of the May, 1985 *Michigan Medicine*. In this article on diving accident treatment on page 278 and 283, the comment is made that "this grant will allow the hospital to reactivate its recompression chamber so that recreational or sport divers may have access to necessary treatment within Michigan." This sentence would imply that there is not access to necessary treatment in Michigan and, in fact, this is incorrect. Both Bronson Hospital in Kalamazoo and Butterworth Hospital in Grand Rapids have monoplace chambers which could satisfactorily treat most cases of decompression sickness with little difficulty. In fact, they would be the preferred sites rather than going clear to Milwaukee since the speed of access to these chambers would probably be greater. Bronson Hospital has its own "CareFlight" helicopter service which allows rapid transport of the dive accident victim. Certainly it is controversial whether or not attempts should be made to treat air embolism in a monoplace decompression chamber and many of us feel that speed is the issue and not the extra three atmospheres allowed by the multiplace chamber.

I applaud the Alpena County General Hospital for setting up a multiplace chamber at their facility for the treatment of dive accidents in their area. There is no question with the huge amount of sport diving in that area it is a sorely needed and greatly appreciated service. For divers in the lower Michigan area however, I feel it is inappropriate to state that appropriate recompression facilities are not available. Here in Kalamazoo and throughout the state, I have been active in diving medicine. Bronson Hospital has on-call 24 hours per day, capability of treating patients in our two monoplace hyperbaric chambers. Certainly any decompression illness in the Southwest Michigan area would do well to be taken to either Kalamazoo or Grand Rapids.

John W. Dircks, M.D., FCCP
Co-Director,
Hyperbaric Oyxgen Facility
Bronson Methodist Hospital
Kalamazoo

Past president keeps in touch

1969-70 seems like a long time ago—especially when I read so many names of people I do not know. But through these 15 years you have kept me in touch with MSMS activities through "Medigram". I have written you many a letter in my mind—but that seldom gets down on paper.

So, an "orchid" to you for a job being well done and a big "thank you" for keeping me on your mailing list, thereby letting me still be a very interested "old timer" in the MSMS activities.

Having fallen in love with sailing—while serving as the pediatrician at the Naval Academy during World War II—we retired to Oxford, Maryland which is the sailing capitol of the eastern shore. Needless to say my first purchase was a new sailboat which we thoroughly enjoyed. However I was too healthy and active to stay quiet—so I became a part-time (18 hours per week) consultant in pediatrics and general medicine at the Eastern Shore Hospital Center. Thus seven happy years passed.

Now for the past four years we have been in a Quaker Perpetual Health Care Center in suburban Baltimore—17 miles from Harbor Place in rolling farm country. We are healthy, happy and very active—but now at 82 it takes me longer to do things. Good cheer.

Robert J. Mason, MD
Cockeysville, Maryland

Law and medicine relationship

The article by Adelman, Friedman, and Simons in the May, 1985 edition of *Michigan Medicine*, gives an excellent overview of the sad state of relations between the ancient and honorable professions of Medicine and Law.

The authors' reasoning is flawed, however, when they suggest that, "Perhaps a greater understanding between the professions could reduce the high cost of medical malpractice insurance..." To the contrary, "greater understanding" as a means of moderating the malpractice crisis is impractical to the point of irrelevancy.

The central issue in the malpractice problem is the adequacy of the legal system to address questions of professional negligence. I won't catalogue what many feel are those inadequacies; but any philosophical posturings to the contrary are smokescreens hiding a basic fact: maintaining the current system of resolving civil disputes is a pocketbook issue for lawyers on both sides of the liability fence. How can it not be when anywhere from 50-60 percent of the malpractice insurance premium dollar goes to lawyers?

And we all know that, after hunger and sex, money is one powerful engine driving human behavior. Within this context I personally am pessimistic that any understanding between the professions is possible.

And even if it were, it's probably irrelevant anyway. The public is going to decide where its interests lie on this malpractice issue: whether the value of the existing tort system justifies the dislocations in health care delivery that are bound to come, if they haven't indeed come already.

W. Peter McCabe, MD, President
Wayne County Medical Society

By Jack Ryan, M

Eight suggestions toward easing the crisis

The malpractice insurance environment in Michigan is a crisis, inside a disaster, wrapped up in a catastrophe. The situation is, in fact, quickly approaching proportions much like those of the mid-1970s. During that time, as now, malpractice insurance costs increased dramatically. Annual premiums for comparable coverage in non-surgical practice, for example, rose ten-fold.

Malpractice judgment amounts and litigation rates increased dramatically as some physician specialists found it extremely costly or impossible to obtain adequate coverage. Rising judgments and the cost of litigation, coupled with a poor market for insurance company investment portfolios contributed to firms leaving the market for medical malpractice insurance. Thanks, in part, to state initiatives like the Brown-McNeely Fund, the symptoms, if not the cause of the crisis, were treated adequately.

Now it appears that a decade later we averted a malpractice disaster but left the underlying root causes to return and haunt us. During the past eight years the number of claims against insured physicians has jumped from five per 100 to 23 per 100. In 1982, less than 35 percent of case closures found for the plaintiff. Yet defending against even an unsuccessful lawsuit has become an increasingly costly proposition, rising 73 percent over the past eight years.

The cause of the past crisis—the high cost of insurance against malpractice losses—is still with us however. This time, as before, it manifests itself not just in the lack of availability of insurance coverage, but also in the cost of coverage. Insurance experts predict that between several hundred and 1,500 obstetrician/gynecologists will be unable to obtain malpractice insurance coverage in Michigan as insurers become more discriminating in whom they will cover. Those who can obtain coverage face premiums as high as $48,000 per year in Oakland County.

Negative effects

These events are having serious negative effects on health care consumers. Michigan hospital malpractice insurance costs for basic limits coverage are among the highest in the country. These costs are ultimately passed on to the consumers of health care. Average annual premium costs per occupied hospital bed are nearly $2,600 in the Detroit area. In the state, as a whole, the average annual cost is about $1,748 per occupied bed. Compare these figures to the $610 average premium cost per occupied bed in Indiana, or the $550 average cost in Ohio and you will see the extent of the crisis.

This cost to the consumer is, unfortunately, the least of our problems. The increasing exposure of physicians to possible malpractice suits is causing man to alter their practice patterns. Physicians are now using sophisticated patient screening methods to avoid treating high-risk patients. In Wayne County, for example, this is having a negative effect on efforts to improve prenatal care for the medically indigent in inner-city Detroit.

Perhaps the greatest cost associated with the medical malpractice crisis is in the high reliance on defensive medicine. Although a definitive figure is difficult to obtain, experts estimate that defensive medicine adds te to 25 percent to the total cost of health care. As physicians ad to the number of tests and procedures in order to provide a legally as well as medically defensible record of care, the cost to all consumers, including you an me, has invariable escalated.

As providers, we have a stron professional and personal understanding of the causes and effect of high malpractice insurance costs. We feel that a number of measures can be taken to avert this crisis, preserve a fair and swif judicial process and control health care costs.

Suggested measures

First, we suggest a broadenin of the role of the Michigan Mal-

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Doctor Ryan, Detroit, is president of Michigan Hospital Association.

About this Special Report . . .

Michigan physicians and their professional liability insurance companies told interested legislators at a Senate Judiciary Committee hearing in Detroit last month that the medical malpractice insurance situation has reached crisis proportions. Louis R. Zako, MD, chairman of the MSMS Special Task Force on Professional Liability, warned there is "imminent danger of having the system topple." Several additional perspectives were offered as many MSMS members testified. Much of that testimony is reprinted in this Special Report. Senator Patrick McCollough (D-Dearborn) said the legislators would "rely heavily" on the doctors' testimony as they shaped new liability-targeted bills for fall.

practice Arbitration Act which determines if a plaintiff has a valid claim against a health care provider based on his or her failure to comply with a standard of care. We feel the panel should be used as a condition precedent to filing a law suit. This would provide an effective screen against frivolous law suits and protect providers against the high costs of defending against such cases. The opinion of the panel should be admissable as evidence in any subsequent trial and the plaintiff or defendant would have the right to have any panel member appear in court.

Second, we feel that the doctrine of joint and several liability in medical malpractice cases should be eliminated. If replaced with a fairness clause, this would eliminate accountability based on which defendant in a malpractice law suit has the highest insurance limits (or the deepest pocket) and base it on the degree of responsibility for the medical maloccurrence.

Award limits

Third, we suggest a limit on recovery of non-economic losses. We view this as an essential element in curbing the increase in multi-million dollar judgments for pain and suffering and other non-economic losses which have been seen in the medical malpractice area in recent years. The average malpractice award against hospitals and physicians as a group increased from $240,000 to $962,000 between 1977 and 1982. The increase in malpractice insurance premiums is largely the result of the severity of these claims. Not only do enormous awards increase the cost of health care for all consumers, they threaten to make the system of tort reparation unworkable if the upward trend in jury awards continues.

Fourth, we feel that there are compelling reasons for the elimination of collateral source, or double recovery. It is difficult to justify collateral source in today's economy. A claimant who has already recovered part or all of his or her medical bills or lost wages should not recover them again in a tort suit. We think that the court should be required to reduce any judgment by an amount equal to collateral source payments with certain exceptions such as life insurance workers compensation.

Fifth, we support the elimination or reduction of prejudgment interest. Interest is now added to any judgment based upon tort at a rate of 12 percent per year, compounded annually from the date of filing the complaint. The present interest statute should be amended to reduce or abolish prejudgment interest. In any event, section (5) of the interest statute should be amended to provide that "the court shall order that interest shall not be allowed beyond the date of a written offer of settlement to the extent that the offer is substantially identical or more favorable than the final judgment."

Sixth, there is a need for restrictions on expert testimony that set standards for qualification of expert witnesses. With respect to an action against a non-specialist, there should be a requirement that the witness must devote not less than 75 percent of his or her professional time to the actual clinical practice of medicine.

If the action is against a specialist, the witness must also be required to specialize in the same area of medicine as the defendant and must devote not less than 75 percent of his or her time to active clinical practice in the same specialty as the defendant.

Continued on page 380

Statute of limitations

Seventh, we support some form of change in the statute of limitations which holds physicians and hospitals at risk for their participation in the delivery of a child up to 20 years after the individual was born. This statute, combined with the high-risk nature of childbirth and some of the highest malpractice insurance premiums of any specialty group, are encouraging many obstetricians to change their area of specialization.

Eighth, and finally, the legislature should provide for periodic/interim payment of large awards, and a halt to payments on the death of the beneficiary unless survived by a legal dependent. The purpose of this is three-fold: 1) to prevent a claimant who may require continuing care from spending lump sum settlements, thereby leaving nothing for future medical and other needs; 2) to avoid providing windfall for other family members in the event of the claimant's death; and 3) the structured payments create less strain on insurance company reserves and have the effect of lowering premiums for malpractice insurance.

In promoting these solutions to the malpractice crisis, the Michigan Hospital Association is pursuing several goals. We wish to reduce the number of malpractic lawsuits which, even when frivolous, are extremely costly to defend against. We also wish to change the incentive structure which is now growing for physicians to avoid high-risk consumers. Finally, we want to reduce the practice of defensive medicine which places an emphasis on legally defensable rather than cost effective and efficient medicine.

Actions such as those that I have outlined can represent the single most important health care cost containment effort the legislature has undertaken in recent years, and it would be accomplished with the full support of all Michigan providers.☐

Tort system abuses at the heart of crisis

Abuses of our tort system are rampant. Our courts are flooded with groundless and frivolous lawsuits. Attorneys deliberately drag out cases for years in order to increase their own fees. Our legal system deserves its bottom of the barrel public image. These are not the laments of a frustrated anesthesiologist, but a synopsis of remarks made by the Chief Justice of the United States Supreme Court, Warren Burger, in front of a meeting of the American Bar Association.

Unfortunately, at least as it relates to Michigan and the healthcare industry, Chief Justice Burger grossly understated the degree of legal harrassment to which we are subjected. Michigan and Wayne County courts are flooded with malpractice suits. Every year brings a sharp increase in the number of such suits and in the cost of defending and settling them. Malpractice premiums are skyrocketing. Premiums in excess of $50,000 for basic coverage are becoming commonplace. Many doctors cannot get insurance at any price. By the end of the year, more than 1,000 Michigan doctors will be uninsurable.

Doctors who can't get insurance can't practice—hospitals require staff physicians to carry insurance. Which doctors are going to be eliminated by our malpractice crises—bad doctors? Not really. For the most part, they will be the best doctors in our system; the doctors who are willing and who have the expertise needed to care for the most seriously injured, the sickest, and the most difficult patients—the patients who have a high percentage of less-than-perfect results no matter how expertly they are treated.

In our current system, the less-than-perfect result, *not* malpractice, triggers most lawsuits. Therefore, the doctors we lose will be the orthopedic surgeons willing to tackle mangled automobile accident victims, trauma surgeons, neurosurgeons, and obstetricians who are willing to work in poor urban neighborhoods. These are the doctors who, because of the nature of the patients they treat, cannot guarantee perfect results. They are also the doctors most needed by the public.

A public crisis

The malpractice crisis is not really a battle between doctors and lawyers. It's a public crisis and, like any social crisis, the poor are first and foremost affected. An obstetrician practicing in a poor Detroit neighborhood, for example, must do between 150 and 200 deliveries a year just to pay his malpractice insurance, if he can get insurance at all.

Under these conditions, a physician cannot meet expenses, much less make a profit. As a result, poor neighborhoods are

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Doctor Horsch is president-elect of Wayne County Medical Society.

By Richard Horsch, MD

Doctor Horsch testifies before the Senate Judiciary Committee.

underserved by physicians, and the poor are denied the continuing and integrated obstetrical and other medical care that they so desperately need. Detroit now has the highest infant mortality rate in the nation, a rate that is climbing as rates in other cities are dropping. Detroit's rate is higher than the rates in many third world countries and significantly higher than such cities as Gary, Indiana whose social problems are as great or greater than those of Detroit. The poor already are paying a terrible price for the litigation crisis.

Although care is still readily available to affluent patients, they, too, are paying a steep financial price for our crisis. Doctors, in order to survive, are forced to practice defensive medicine, ordering a multitude of tests and consultations that have legal and not medical indication. The public pays for these tests.

The cost of huge malpractice premiums are also passed on to the public. Where does this money go—to injured patients? Unfortunately, patients receive less than 30 percent of the malpractice premium dollar. Insurance companies get a little less than 10 cents on the dollar. Attorneys get over 60 percent of the malpractice dollar—more than twice as much as the injured patients for whom the system supposedly functions. Attorneys, not patients, are the beneficiaries of the system.

A massive tax

In effect, our tort system imposes a massive health-care tax on all of our citizens, which is then distributed among various plaintiff law firms. Under our current contingency system, payments to attorneys can be enormous. Structured payments for a single case, to a single attorney, have reached $6 million. No wonder they file a multitude of groundless, shotgun malpractice suits that cost physicians between $35,000 and $250,000 to defend, even though the doctor is eventually found to be innocent, as we are in nine out of ten jury verdicts. Unfortunately, since the defense of a case is so expensive and since the risk of a huge multimillion dollar verdict accompanies any jury trial, most cases are settled regardless of the merit of the charges. The public, in the end, pays for this fiasco.

Some doctors are just as eager as attorneys to make a buck out of our malpractice crisis. Plaintiff expert witness companies flood legal journals with advertisements to testify against other doctors, in effect, willing to go anywhere and say almost anything if paid enough to do so.

The basic problem

It must be recognized, however, that the basic problem is not attorneys or doctors but our current tort system. Because our tort system richly rewards, rather than punishes abuse, abuse is rampant. We have long looked toward our court system and the legal profession to correct these abuses. We have waited in vain. It is obvious that they will never do anything to interfere with this goose which lays so many golden eggs. The necessary corrections of our perverted legal system will have to come from the legislature. To correct the perversion of our tort system, we need reforms that once again create a fair system, a system that functions for the benefit of the public instead of the benefit of the legal profession, a system that awards most of the proceeds of litigation to injured parties and not to attorney bank accounts.

We need a tort system that appropriately punishes those who abuse it and which holds those attorneys who injury innocent parties via goundless lawsuits accountable for that injury. We need reforms which restore our tort system as it was intended by our founding fathers—a system that functions to protect the rights of citizens.☐

By Kevin Clinton

Insurance official explains carriers' rates and reserves

Substantial rate increases and restricted availability of medical malpractice insurance in recent months have caused increasing debate from bar association groups and medical societies.

Some observers of medical malpractice suggest that the insurance industry has created a phony medical malpractice problem in Michigan in order to reap excessive profits. They accuse the insurance industry of inflating predicted future claims and of failing to include investment income in the calculation of rates and underwriting losses. They point to the large and growing asset balances and infer that premium rates and reserves must be excessive.

These critics of the insurance industry are apparently attempting to cloud the issue at hand, as their comments indicate they are unfamiliar with insurance company ratemaking and reserving practices, at least as it is applied to companies marketing and selling medical malpractice insurance in Michigan.

An underwriting loss occurs when losses and expenses exceed earned premium. By definition, an underwriting loss excludes investment income. However, both the underwriting loss and investment income are considered in setting rates. Doctors insured with Michigan Physicians Mutual Liability Company or Physicians Insurance Company of Michigan, both Michigan-based insurers and who are the two largest writers of medical malpractice insurance in Michigan, currently receive a 25-30 percent discount in their rates due to the consideration of investment income. These companies also consider investment income when setting reserves. As an example, if $1,000 is expected to be paid 5 years from now, and losses are discounted at nine percent interest, only a $650 reserve is set up. The remaining $350 is expected to be earned through future investment income from the $650 reserve.

Accepted practices

For those who believe that insurers are hiding profits, they should question why a company would set up a $650 reserve and take a $650 tax deduction when the IRS allows the full $1,000 to be reserved and deducted. The answer is that insurers cannot afford to reserve the full $1,000 and must depend on future investment income in setting their reserves. While this is an accepted accounting practice, the one preferred by IRS, it causes an acceleration of reported earning. As an example, Michigan Physicians Mutual Liability Company reported $8 million of surplus as of December 31, 1984. This $8 million surplus, however, is dependent upon them earning $40 million of future investment.

Large asset and reserve balances are an expected and necessary part of the medical malpractice insurance process. In Michigan, the average claim is not reported until two years after its occurrence. The average claim is not paid until 5 years after the malpractice incident although payments may extend decades beyond occurrence Without large asset balances, an insurer would be unable to pay covered claims.

Long payment tail

It is difficult to comprehend the length and breadth of the medical malpractice payment tail. An example is provided by the experience of Pacific Indemnity Company, a member of the Chubb Insurance Group. Pacific Indemnity was a large writer of medical malpractice in Michigan in the early 1970s. Pacific Indemnity ceased writing medical malpractice in Michigan in 1977. In the seven years since 1977, with no additional premium income, Pacific Indemnity has paid over $39 million in direct claims expenses. Claim payments in 1983 and 1984 alone exceeded $11 million. An estimated $7 million in claims remain unsettled. As this case shows, large reserves are a necessity for medical malpractice insurers.

Major writers of medical malpractice in Michigan have increased premiums 50-60 percent in the past 12 months. If these insurers had not taken this action, the Insurance Bureau would have been forced, by law, to require them to increase rates. The existing rates were below cost and the continued use of such rates would have endangered the solvency of these companies. ☐

Mr. Clinton is a Fellow of the Casualty Actuarial Society; member of the American Academy of Actuaries; and Chief Actuary for the State of Michigan Insurance Bureau.

By William G. Olsen

PICOM chief tells that carrier's story

Sen. Rudy Nichols

A panel of legislators listens intently to the testimony. From left to right: Sen. Alan Cropsey (R-Dewitt); Sen. Rudy Nichols (R-Pontiac); Rep. Teola Hunter (D-Detroit); and Sen. Basil Brown (D-Highland Park).

There are three major causes of what we call the "malpractice crisis." First, there has been an enormous increase in the frequency of malpractice suits in recent years.

Second, everyone agrees that the size of jury awards has increased in recent years. Because of this, the average indemnity per paid PICOM claim has almost doubled in the last three years—*and the important thing to note is that this enormous increase is eight and a half times greater than the increase in the cost of living in that three year period, with absolutely no evidence that average patient injuries or suffering were more serious in 1984 than in 1981*. Third, the legal cost of defending the average closed claim against PICOM insureds has increased 83 percent in three years. It now costs our company almost $6,000 to defend the average claim. And mind you, 50 percent of the claims filed against PICOM are dismissed without either trial or the payment of indemnity—yet the legal cost of defense must still be paid in each one of those cases.

Finger pointing

Lawyers, doctors and insurance companies are all in agreement with these three facts but there the agreement stops and each side seems to be pointing fingers at the other side as the major culprit in the malpractice crisis. Some of this finger pointing has led to some absurd charges and unfair conceptions.

The people who have made unfounded charges against insurance companies in this state have also suggested that somehow the insurance industry has hidden undeclared profits by overstating its necessary loss reserves. Far from being overstated, PICOM's loss reserves were, in fact, found to be understated in 1984 because PICOM's actuaries and auditors had not foreseen the scope of the continuing escalation in the frequency of suits and the rapid rise in the size of judgments and the costs of defense.

Regarding the charge that PICOM is somehow receiving and concealing exorbitant profits from investment income—certainly PICOM invests the money that is set aside to pay the costs of future claims. Every insurance company does. It is part and parcel of the theory of insurance. But PICOM reports all income from investments to the Michigan Insurance Bureau and publicly to its shareholders. While we are proud of our investment return, it is not exorbitant at 10.5 percent and certainly it is not secret.

Moreover, PICOM's investment income is used to *reduce* the premium that physicians would otherwise be required to pay for their medical liability insurance. In 1984 the charge that PICOM made to physicians for their insurance was only about two-thirds of what the company expected each policy (on an average) to cost it over as many as 20 years of potential risk. The other one-third will come from investment income all of which is factored into premium rates

Continued on page 384

Mr. Olsen is president of the Physicians Insurance Company of Michigan, a stock insurance Company domiciled in Michigan.

under regulations of the Michigan Insurance Bureau.

Dividing the pie

PICOM expenditures in 1984 were about $17,957,000. Of this amount injured patients received about $7,179,000. But the legal fees, that is the money paid to lawyers on both sides, not including legal expenses, was actually greater than the net amount received by injured patients. When you add together the legal costs and fees of both sides, it is apparent that the resulting $9.3 million is indeed 30 percent more than the $7.2 million which is received by injured patients.

One of the misunderstandings which has arisen from the medical malpractice crisis is the belief that it is the undertrained or incompetent or impaired physician who causes all the problems. While PICOM does not suggest that these are not a part of the problem of malpractice, it would be a serious mistake to believe that that is the major part of the problem. PICOM's files show, in fact, that malpractice cases are more often filed against the more carefully selected, the most highly trained and the more skilled members of the medical profession.

The fully qualified neurosurgeon has received 10 years of post-college training before he or she is permitted to practice the specialty. Even after than, most neurosurgeons study further, and many of them pass difficult examinations and become Board Certified in their specialty.

Bad doctor theory

Now if the "Bad doctor theory" is correct, one would expect that as the training and skill and experience of these fine surgeons increases, their malpractice suit rate would decrease.

But that is exactly what PICOM's records do not show.

When we compared the noncertified neurosurgeons' suit rate with the suit rates of those who had reached higher plateaus of recognized training, skill and experience, it was very notable that those having greater achievements were likely to be sued *more*, not less. A board certified neurosurgeon is 21 percent more likely to be sued than a non-board certified neurosurgeon. If that board certified neurosurgeon is also a Fellow of the American College of Surgeons, he or she is 31 percent more likely to be sued than the non-board certified neurosurgeon.

And the same thing is true in other specialties such as plastic surgery and obstetrics-gynecology.

What that means, of course, is that the more skilled the key physicians, the more experience they have, the more distinguished they become among their peers, the more likely they are to be sued.

This is not what the public understands. It is not what has been charged by many. The reason for this paradox is that top-flight physicians get and accept the toughest cases where a bad result is often likely or even expected; where the condition or disease was perhaps not even treatable a decade ago; where the techniques of treatment, while not experimental, are not absolute, and are changing every day.

PICOM does not call these men and women "bad doctors".☐

Malpractice crisis threatens health ca for Detroit's homele

The Detroit Health Care Coalition for the Homeless (DHCCH) was successful in obtaining foundation support as one of 18 cities selected to demonstrate that health care can be delivered to homeless persons in a manner consistent with accepted standards of care. We have done detailed planning of how staff will endeavor to deliver care in the multiple designated sites around the city, as well as the clinic site located within Detroit Receiving Hospital.

However, we have not yet begun, because the final major stumbling block was the refusal of all three major carriers in Michigan to grant us malpractice insurance. We had requested insurance coverage for three licensed physicians, two of whom are board eligible in internal medicine. None have any negative malpractice experience.

Upon further contact with the Physicians Insurance of Michigan we finally received applications. Following two weeks of deliberations in their Detroit and Lansing offices, coverage was denied. It was denied based upon the nature of the population to be served! Subsequent appeal to the Medical Protective Company has provided us with a set of applications which are being processed.

Silas Norman, Jr, MD, is Assistant Professor of Medicine at Wayne State University, Vice Chief of Medicine at Detroit Receiving Hospital, and Clinical Coordinator of the Detroit Health Care Project for the Homeless.

Significant problems

Denial of coverage created

By Silas Norman, MD

significant problems for us, since we did not anticipate it. In my experience, persons *without* negative histories are *not* denied coverage, nor are their rates increased. I do not believe there is any data to support the contention that homeless persons pose greater malpractice risks than the general population; they appear to be scapegoats in this crisis situation! Physicians who dare to serve the poor find themselves stranded, forced to serve and accept risks not demanded of colleagues who work in economically advantaged areas.

We, as general practitioners and internists are in the least taxed malpractice category. Last year the cost of our insurance was approximately 1/40 of our income. By 1985, it is costing us 1/30. By July, 1985, it will cost 1/12; and the prospects are that it will cost 1/6 by July, 1986. (This in the face of fees which are frozen for almost all classes of patients and carriers and cost containment measures like the Diagnosis Related Groups.)

We are facing rising costs and limited and discriminatory coverage! Not only do persons who work on projects such as ours stand to suffer, but virtually every physician who works in areas of greatest need will find himself at higher risk!

It is imperative that we find new ways to assure that the poor and those who serve them are not saddled with an unfair share of the malpractice problem. The denial of insurance to the homeless is an ominous sign.☐

By Cecil R. Jonas, MD

This crisis could worsen Detroit's infant mortality

The Detroit Medical Society is the local arm of the National Medical Association, and has a long and abiding interest in inner city health. Over the last three years, we have watched the gradual increase in infant mortality in Detroit, to the point where it now rivals the figures of several Third World Countries. The appalling statistics are well documented by the recent Governors Task Force chaired by Doctor Gloria Smith of the Public Health Department.

In 1982 the U.S. mortality was 11.00, the Detroit white mortality rate was 9.4 and the black mortality rate was 26.9.

The uncollated 1983 mortality rate of 19.9 for the entire city is compared to 10.9 for the country; and 23.1 for the black infant in Detroit is compared to 11.4 per thousand for the white community. It is evident that the black infant mortality rate is considerably higher than that for the whites.

In 1984 the Detroit Medical Society made this the subject of their Clinic Day Program and secured the help of the Michigan State Medical Society and the Public Health Department in identifying those areas of the city which show the steepest rise in infant mortality. The Wayne County Infant Health Promotion Coalition which has an information referral service — 961-BABY — helped us target two public health centers in the northwest section of the city which reflect the highest number of calls in relation to the number of live births.

The purpose of the 961-BABY number is to direct women to public clinics offering prenatal and pediatric care free of charge or at a greatly reduced cost. The Detroit Medical Society was able to encourage approximately eight obstetricians and pediatricians who were willing to work in these public health clinics. The plan involved using existing public health centers where we could utilize the abilities of the other health care providers, such as social workers, nutritionists and other outreach persons to identify the pregnant patient early in her pregnancy, to encourage her to make frequent and timely visits to the prenatal clinic there to be observed by obstetricians who would see her through the prenatal course and delivery.

Lawsuit targets

The Detroit Medical Society and Michigan State Medical Society remain committed to this project and acknowledge a moral obligation to do so. To be realistic, however, these obstetricians, along with neurosurgeons and orthopedic surgeons are prime targets for lawsuits. Many of the physicians who have agreed to volunteer their services have found themselves facing a fifty to one hundred percent increase in malpractice costs. I am faced with a $35,000 malpractice bill for the upcoming year starting July 1st — up from $17,000 this year. Some of my colleagues are being dropped completely, while others are expecting to overpay. Many of these suits are settled in favor of the physicians, however, the insurance industry claims that the cost of defending a suit has increased approximately 73 percent over the past eight years, making defense against even a frivolous claim a potentially expensive proposition. In addition, it is a well known fact that defense costs are often weighed heavily in decisions by insurers, as to whether to settle a suit out of court even if the likelihood of success is high. Obviously, this has a tremendous bearing on the ability to continue to offer free service to the medically poor, and indeed the Medicaid population, where reimbursement is only 40 to 45 percent of the charge. Providing care to women in pregnancy,

Continued on page 388

Doctor Jonas is vice-president of the Detroit Medical Society.

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childbirth, and the period immediately afterwards is financially risky. In the present malpractice situation in Wayne County any maloccurrence can result in not only a lawsuit, but in an astronomical settlement. The ethical dilemma of the physician is compounded when he is asked to provide concerned and caring service, free of charge, to a patient who can well be a litigant in a malpractice suit.

This, then, is our ongoing fear — that practicing high risk obstetrics in this group of indigent mothers can prove to be financially suicidal in the event of a less than perfect outcome. Several potential sources of funding are being considered. The city understands and sympathizes with our problem and is willing to help. The matter is still under advisement but we recognize that it too has financial considerations that might preclude its underwriting the premium costs for this malpractice coverage.

The state or the city, if indeed they would agree to do so, would insure the Physicians only for those patients covered in the public health clinics. The cost to the city or the state for the free prenatal care would be limited to the cost of insuring the physicians.

The legislative mandate emanating from the Governor's Task Force, recognized the importance of prenatal and post partum care and offered the vehicle of "basic health services" as the means of assuring its availability and accessibility on a state wide basis. This is evidently of highest importance to public policy makers, as indeed it should be.

The efforts of the Detroit Medical Society and the Michigan State Medical Society can help to facilitate this and move towards the goal of HHS of nine infants deaths per thousand per year by 1990. Legislative relief is urgently needed to restore some balance and common sense to the current civil justice system.☐

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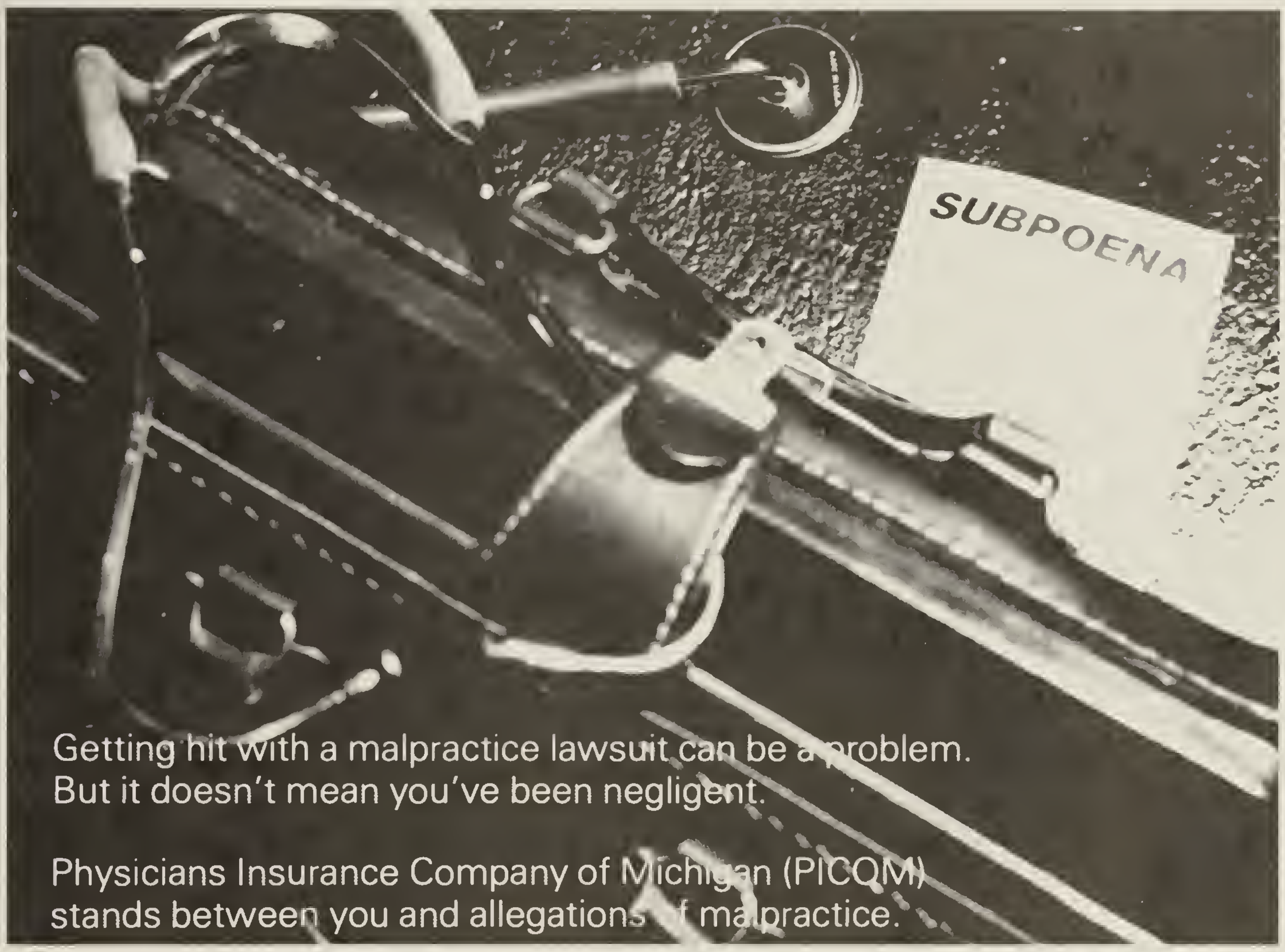

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Heed this legal advice regarding seat belt exemptions

Act No. 1, Public Acts of 1985, mandating seat belt use, takes effect on July 1, 1985.

Section 710e(3) provides as follows:

Each driver and front seat passenger of a motor vehicle operated on a street or highway in this state shall wear a properly adjusted and fastened seat belt, except that a child less than four years of age shall be protected as required by Section 710d. Each driver of a motor vehicle transporting a child four years of age or more but less than sixteen years of age in the front seat of the motor vehicle shall secure the child in a properly adjusted and fastened safety belt.

Section 710e(l) sets forth exceptions. These exceptions include motor vehicles manufactured before January 1, 1965, a bus, a motorcycle, a moped, a motor vehicle not required to be equipped with safety belts under Federal law and postal service vehicles in specified instances. The exception which must be understood by physicians and the focus of this article is set forth in Section 710e(l) (e). That statutory exception provides as follows:

This section shall not apply to a driver or passenger of:
(e) A motor vehicle if the driver or passenger possesses a written verification from a physician that the driver or passenger is unable to wear a safety belt for physical or medical reasons.

Exemption requests

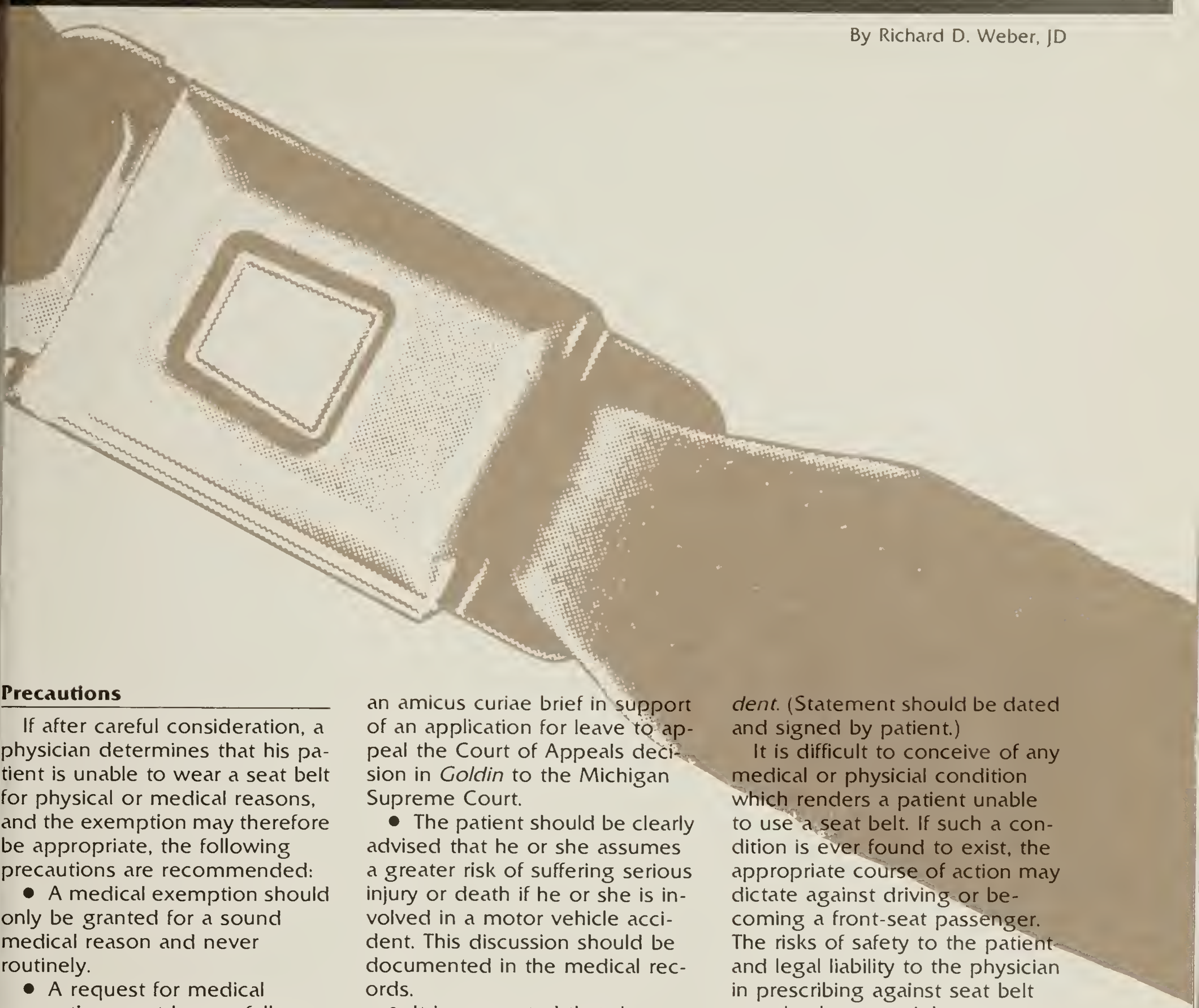
It is difficult to conceive of any physical or medical reason which would justify a physician granting a "prescription" to a patient to trigger this exception. Arguments might be made that certain conditions, such as pregnancy, pacemakers, deformities and other conditions are sufficient to avoid the seat belt requirement. It is suggested that proper adjustment of seat belts might well accommodate any of these conditions. Whether any physical or medical reason does justify the application of the exception is, of course, a medical decision. Because of the benefits of using a seat belt, physicians should weigh very carefully the advantages of reducing the risk of injury or death to the patient who drives against any medical or physical reason that the patient may give for seeking an exemption. Physicians must realize that this risk of not using a seat belt based upon the statutory exception rests not only with the patient; there is a clear liability risk to a physician who prescribes the non-use of a seat belt.

A physician granting an exemption may be held personally responsible for his action and should be prepared to defend the exemption in court. It is clear that seat belt restraint reduces serious injury and death in automobile accidents. Any physician granting an exemption may be sued by a patient who is injured or killed in an accident, where it is alleged that the injury or death is caused or contributed to by the lack of a seat belt. Moreover, it is possible that a physician could be sued by a non-patient third party based upon the allegation that the physician's patient, in not wearing a seat belt, somehow lost control and caused an accident resulting in injury or death to a third party. This third party potential claim becomes more conceivable in view of the recent Michigan Court of Appeals decision of *Duvall v Goldin*, Michigan Court of Appeals Decision No.74082 (decided December 3, 1984).

In *Goldin,* a physician was held liable to a third party as a result of prescribing a drug to a patient who was involved in an automobile accident attributable to the drug.

Mr. Weber is an attorney with Kerr, Russell and Weber, Detroit, MSMS legal counsel.

By Richard D. Weber, JD



Precautions

If after careful consideration, a physician determines that his patient is unable to wear a seat belt for physical or medical reasons, and the exemption may therefore be appropriate, the following precautions are recommended:

- A medical exemption should only be granted for a sound medical reason and never routinely.
- A request for medical exemption must be carefully reviewed and all possible encouragement given to the patient to adapt the restraint system to the patient's condition (i.e., adjusting the position and height of the car seat and adjusting and positioning the safety belt) before making a decision.
- If a medical exemption is granted, a record should be kept by the physician of the medical reason(s) given by the patient for the exemption, the documentation of the basis for which the medical exemption was granted, the date it was granted and the expiration date, if any. If the condition is temporary, a time limitation on the exemption should be clearly set forth.

MSMS legal counsel has filed an amicus curiae brief in support of an application for leave to appeal the Court of Appeals decision in *Goldin* to the Michigan Supreme Court.

- The patient should be clearly advised that he or she assumes a greater risk of suffering serious injury or death if he or she is involved in a motor vehicle accident. This discussion should be documented in the medical records.
- It is suggested that the physician require that the patient sign a statement to be attached to his or her medical records to the effect that the patient understands the risk assumed in not wearing a seat belt. While no particular form is required, the following suggested statement could be used:

I have requested Doctor ______ *verify that I suffer physical or medical disabilities which render me unable to wear a seat belt. Doctor* ________________ *and I have discussed the risks involved in not wearing a seat belt. I understand that by not wearing a seat belt, I bear a greater risk of suffering serious injury or death in the event I am involved in a motor vehicle accident.* (Statement should be dated and signed by patient.)

It is difficult to conceive of any medical or physicial condition which renders a patient unable to use a seat belt. If such a condition is ever found to exist, the appropriate course of action may dictate against driving or becoming a front-seat passenger. The risks of safety to the patient and legal liability to the physician in prescribing against seat belt use clearly out-weighs any convenience or comfort concerns of the patient that might be asserted by a patient in attempting to meet the exception. If the unique case does appear and sound medical judgment dictates that the patient is unable to wear a seat belt, but must drive, the physician should take heed of the recommendations set forth in this article. If Murphy's Law does apply, and the physician is sued by the patient or a third party for prescribing the seat belt exception, careful adherence to the recommendations set forth in this article may be the difference between winning and losing the lawsuit. The safe approach, of course, is not to prescribe the exemption.☐

How much pain is too much?

Putting patients in control of their pain medication—particularly morphine—might seem like a dangerous idea. The potential for abuse, even overdose, could be high. Quite the contrary, according to a Henry Ford Hospital study, which found that patients actually give themselves less medication when they are in charge.

This is possible thanks to a new, portable computerized pump device, called the patient-controlled analgesia system (PCA), manufactured by a number of companies. Once a patient is hooked up to this machine, if he feels the need for more medication, he simply pushes a button on a cord attached to the pump. That doesn't mean he can order a constant flow of the drug. There is a built-in safety feature. The amount of medication that can be released over a period of time and the size of each dose are predetermined.

Renal failure breakthrough

Scientists Paul Churchill, PhD, Wayne State University professor of physiology, and Jen-Jar Lin, MD, graduate assistant, believe they have found a chemical mediator in acute renal failure—a condition that claims the lives of 40 percent of its victims. The investigators suggested that it is possible that an antagonist to the chemical mediator involved in much of the dysfunction could be used in clinical settings to ameliorate the severity of acute renal failure in humans.

The chemical mediator is adenosine, a breakdown product of the important molecule ATP. In research described at the 69th annual meeting of the Federation of American Societies for Experimental Biology, the researchers found that a substance known to block adenosine action was able to partly restore kidney function in rats with acute renal failure.

Scientists believe that in the early stages of acute renal failure, damaged cells release a chemical that is directly responsible for much of the dysfunction. The Wayne State investigators reasoned that if adenosine is involved, then drugs that block adenosine's actions should benefit failed kidneys. To find out, they tested theophylline, a known adenosine "antagonist" on rat kidneys. The investigators found that theophylline was able to restore 40 percent of normal function to rat kidneys that had failed because of interrupted blood supplies.

Maternal deaths fall into six categories

The chart on page 394 shows the preliminary assignments of causes of maternal deaths in Michigan in 1983 and 1984. These are preliminary as they have yet to be evaluated by the Michigan Department of Public Health Central Review Commit-

Continued on page 394

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tee. Hemorrhage, infection and toxemia are blamed for 22 of the 36 deaths with infection apparently responsible for 5 respiratory, four cardiac, and one each pancreas, skin and vascular.

Lee B. Stevenson, MD, Southfield, member of the MSMS Committee on Maternal and Perinatal Health and at MDPH interpreted these statistics for Michigan Medicine.

A diagnosis of "irreversible hemorrhage" could be applied to the two cases of DIC and possibly to the two cases of ectopic pregnancy. Cerebral hemorrhage may not be preventable but it can be treated successfully with early diagnosis and adequate facilities. The rupture of an old aortic graft and of a splenic artery aneurysm probably are not preventable by today's standards. Pulmonary embolism was involved in 8 per cent of the total deaths. Two of these three occurred while the patient was at home. The presence of diabetes on this chart shows that it still is not under control because of the basic problems of patient compliance. Drug abuse is another example is this situation. Finally, there are the non-selective auto accidents and malignancies which affect pregnant as well as non-pregnant women.

Reye's Syndrome update

Two cases of Reye's Syndrome have been reported in Michigan children since April 22. The total number of Reye's Syndrome cases reported since October 1, 1984 now stands at 12 with three deaths. Counts of influenza-like illness have remained at baseline levels over the past weeks. ☐

Breakdown of maternal deaths:

	1983	1984
HEMORRHAGE		
Ruptured tubal ectopic	2	0
Hemorrhage (1 abruptio) — D.I.C.	2	0
Cerebral Hemorrhage	1	2
Ruptured Splenic Artery Aneurysm	0	1
Ruptured old aortic graft	0	1
INFECTION		
Pneumonitis	2	0
ARDS	2	1
Heart	2	2
Hemorrhagic pancreatitis	1	0
Toxic Epidermal necrolysis	0	1
Cerebral Thrombosis	0	1
TOXEMIA		
Preeclampsia — cerebral	1	0
EMBOLISM		
Blood	2	1
MEDICAL		
Diabetes	1	2
Drug Abuse	0	2
Convulsive Disorders	2	0
Sickle Thalassemia	1	0
OTHER		
Auto Accident	0	2
Malignancies	0	1
	19	17

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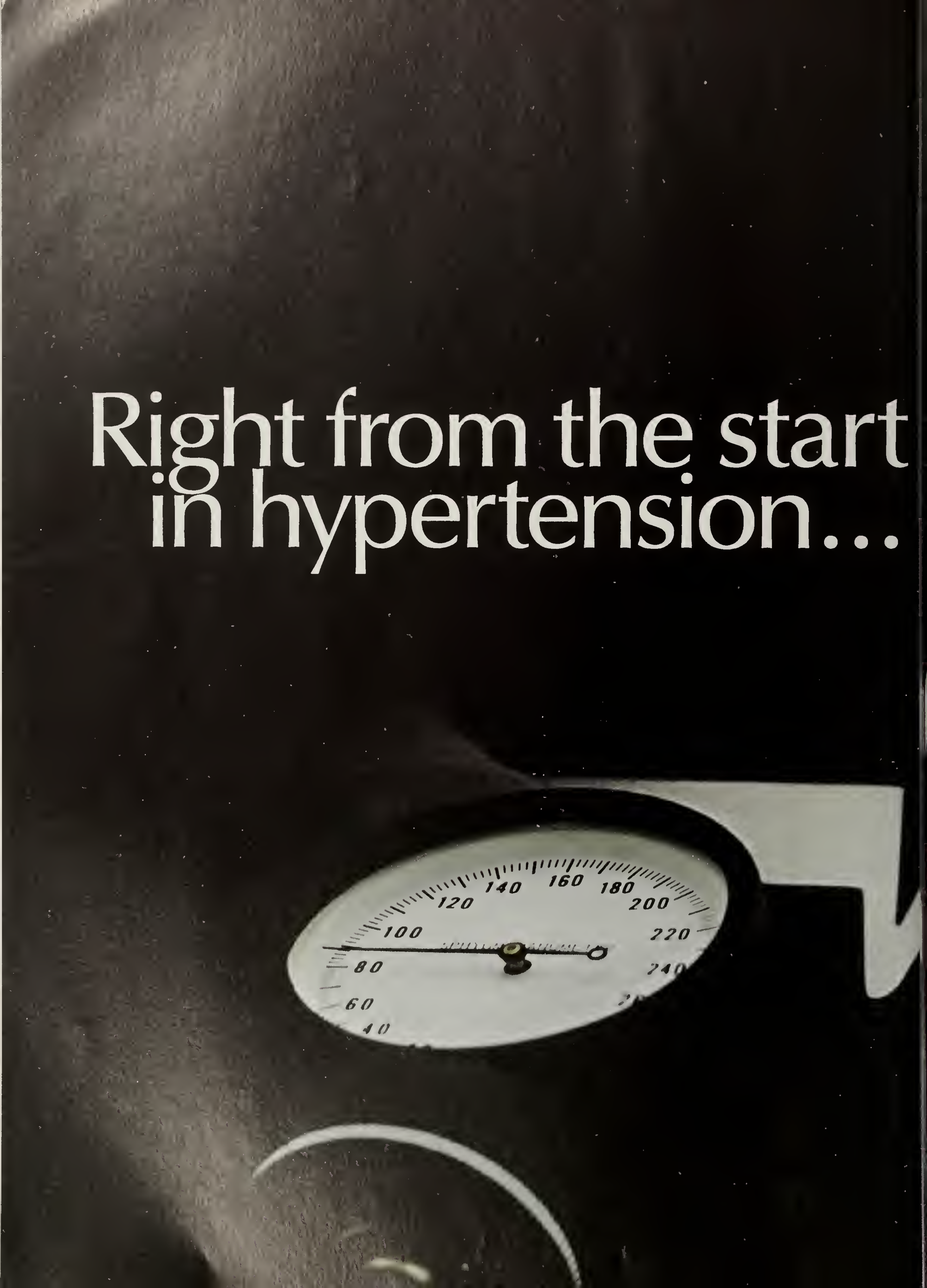
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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

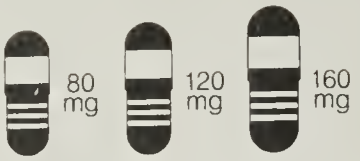
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures



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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g , dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular bradycardia congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70.762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984,251.1298-1299.

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By Willard Stawski, MD

Concerns of women physicians

Reprinted with permission from the April issue of the Kent County Medical Society Bulletin, at the request of Vivian Lewis, MD, chairperson, MSMS Committee on the Concerns of Women Physicians.

Perhaps the most important role of any medical society is to assist its individual members in their quest to derive the greatest fulfillment from the practice of medicine. Like that delicate balance between the art and science of medicine, demands of family life must be carefully balanced with the demands of professional life. Responsibility to family and responsibility to profession weighs heavily on all of us. Women physicians, however, face an entirely different constellation of problems than their male colleagues. Rearing children and maintaining a home are formidable, round-the-clock obligations that inevitably conflict with physician obligations.

The door has not been widely opened for women to assume leadership roles in hospitals, medical schools, clinics, or medical societies. Consequently, many women have not been highly motivated or encouraged to participate in medical organizations that are outside of their scope of day to day practice.

For many years, Michigan State University College of Human Medicine has been committed to accepting at least fifty percent women in its medical school classes. The percentage of women enrolled in medical schools across the country is currently at the 20-30 percent level. If these physicians are not encouraged to take an active role in the economic and political life of our medical community, a great resource will be wasted.

Thus, your Board of Directors, at its March meeting, approved the establishment of a special Committee for Concerns of Women Physicians. Doctor Anna Broecker has consented to develop this new committee which will include medical students, physicians in training, and practicing and retired physicians. By sharing their experiences and ideas and by identifying leaders, concerns and current issues, these women physicians will significantly improve our Society in the years to come. The success of this committee and its contribution to the practice of medicine in Kent County will depend in great measure on the acceptance and understanding of the membership at large.

A reservoir of physicians with new ideas, new goals and great potential is growing. They are dedicated colleagues who are willing and able to shoulder yet another responsibility in the form of medical leadership and decision making. Support, encouragement and appreciation by every member of our Society is needed. The establishment of the Committee for Concerns of Women Physicians is a major step toward opening the door and enhancing the role of women in organized medicine, and will in turn improve the character and quality of our Society.☐

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Survey shows DRGs affect health care delivery to seniors

The following article is a compilation of responses from the Area Agencies on Aging, the office on Services to the Aged-funded case management projects and the Long Term Care Ombudsman in response to questions developed by the National Association of State Units on Aging (NASUA). The questions concern the impact of DRGs on older persons and the health care system.

Are hospitals refusing to admit Medicare patients with certain health problems, or because of advanced age?

There was not much evidence of refusal to admit Medicare patients on the basis of advanced age, however, one geographic area noted that criteria for admittance had become more stringent. For example, a potential patient may experience difficulty due to a weak heart, but must have actual congestive heart failure to be admitted. In the UP there was specific reference to the absence of refusal for Medicare patients but it was stated that the Medicare-eligible population seems less willing to utilize a hospital because of a general misunderstanding and distrust of hospitals, nursing homes, and health care. Other groups reported that hospitals are competing for Medicare patients by offering incentives such as free TV. Citizens for Better Care reported isolated incidents of hospitals refusing admission "because of DRGs " generally without reference to specific health problems.

Are "for profit" hospitals sending certain Medicare patients to public or non-profit hospitals?

The southeast area of Michigan reported that home care providers were "dumping" clients who are unable to pay to non-profit agencies. Citizens for Better Care noted continued complaints of "creaming" (for-profit home health agencies only taking or keeping Medicare or private pay patients and leaving or transferring poorer or Medicaid patients to county-run visiting nurse programs).

Is there a reason to believe that Medicare patients are being discharged too early? Are cases or conditions which used to be treated on an in-patient basis now being treated on an out-patient basis?

Almost all areas that reported indicated a tendency to discharge patients sooner than they were ready. Two basic ideas emerge on this topic. First earlier discharge is acceptable if the appropriate supports are in place upon discharge (case management would be key in this event). In fact one area noted they received *no* formal complaints about early discharge, and stressed that they had an effective utilization review board in place prior to the onset of DRGs. Second, there is a subjective definition of "ready for discharge." Cancer patients in particular are being discharged earlier and then treated on an out-patient basis. Surgery is increasingly conducted on an out-patient basis. Northwest Area Agency on Aging noted that patients were being discharged before being capable of caring for themselves.

Is there an increase in referrals of patients from hospitals to nursing homes? Are the patients being referred to nursing homes sicker than in the past?

There exists a general feeling that there is a tendency to discharge patients to nursing home care when they are unstable. A few areas reported an increased need for additional nursing homes. Only one region reported

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Ms. Olszewski is with the Michigan Office of Services to the Aging.

By Janet Olszewski, MSW

no increase in referral to nursing homes. According to Citizens for Better Care, problems arise when the patient is certified in need of skilled care and no skilled nursing facility bed is available. Hospitals need to be reimbursed for alternate placement days and not charge the patient/Medicare beneficiary.

Citizens for Better Care reported several observations—1) Patients are being transferred to rehabilitative or other district hospital units ("hospital long term care units") not under the DRG reimbursement system; 2) A new level of care, "sub-acute" or "super-skilled," may be incorporated to cover the expenses of nursing homes who have taken on care responsibilities outside the traditional services offered; 3) A heightened hostility between discharge planners and nursing homes after the health assessors determine that the patient's level of health is worse than was reported by the discharge planner, 4) Because of an increase in Medicare skilled home health care claims, HCFA is restricting benefits which leads the patient seeking institutionalization to insure adequate care. A final observation by Citizens for Better Care is that some DRGs may not be economical to individual hospitals because their procedures are not as efficient as they could be according to the stay periods. There is and will continue to be a tendency for hospitals to specialize, which raises concerns regarding access to care due to the carving up of services.☐

By Dorothy M. Kahkonen, MD

DRG impact on medical care

The following article concludes our series of opinions by Michigan physicians on the impact of Diagnosis Related Groups on medical care.

Physicians as a group tend to be conservative and traditional in their management of patients. The diagnostic related group (DRG) method of reimbursement encourages the physician and hospital to consider alternative methods of providing medical care. Outpatient treatment for less acute illnesses and minor procedures is occurring more often when appropriate. Variations from traditional methods and protocols within the inpatient venue are also considered. Decisions of this kind continue to require individual consideration because the presence of complications and/or co-existing medical problems require different approaches. Every patient is an individual with the potential for different needs and responses.

The DRG system has imposed the need for development of alternative methods of treatment on hospitals and physicians. At this juncture it is important for the physician to assume a leadership role in re-evaluating traditional methods of practice not only to ensure continued high quality medical care but also to maintain the interest of the patient uppermost in this process.

The importance of documentation of the patient's status need for diagnostic studies and treatment plan has become apparent. Experience in our hospital indicates documentation of all these aspects of patient care is improving. Education continues to be an important component of this system and efforts to include the public and patients are laudable.

Finally, the potential for development of adversarial relationships between hospital and physicians is troublesome. The financial impact of the DRG system presently is felt most acutely by the hospital which may respond by challenging physician practices. It is important that hospitals, physicians, legislators and insurers collaborate in addressing these issues and continue to function harmoniously for the benefit of the patient.☐

Doctor Kahkonen is a Detroit internist.

PHYSICIANS IN THE NEWS

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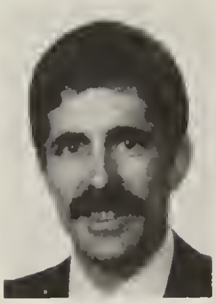
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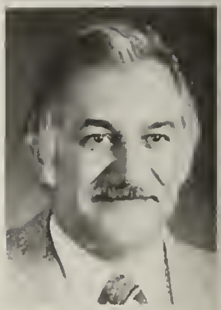
Wilmer

... The Detroit Occupational Physicians' Association has recently elected 1985 officers: **Donald J. Sherman, MD,** Dearborn, President; **Chester J. Bogucki, MD,** Birmingham, president-elect. ... **Vivian M. Lewis, MD,** Flint, received the "Nina Mills Award," in recognition of Nina Mills, founder of the Greater Flint YWCA. ... **Richard D. Judge, MD,** Ann Arbor, was elected trustee of the American College of Cardiology for 1985-90. ... **Bruce Relyea, MD,** of Henry Ford Hospital, was named honorary director of the 9th Annual West Bloomfield Half Marathon. ... **Paul Schreiber, MD,** Portage, recently returned from a medical mission to the Dominican Republic, sponsored by Medical Group Missions of the Christian Medical Society. ... **Ronald S. Taylor, MD,** Bloomfield Hills, has been named advisor to the Michigan Chapter of the National Multiple Sclerosis Society. ... **Gerard B. Martin, MD,** Henry Ford Hospital, received the 1984 Best Resident Paper Award. His paper, was entitled "Insulin and Glucose Levels During CPR in the Canine Model." Honorable mentions went to Joseph W. Kosnick, MD, Detroit, and Randall Best, MD, Detroit. ... **Earl J. Rudner, MD,** Southfield, recently was installed president of the WSU School of Medicine Alumni Association. ... **Maynard Cohen, MD, PhD,** was honored with the 1985 Distinguished Alumni Service Award from the Wayne State University Medical Alumni. ... **Lyle D. Victor, MD,** medical director of respiratory and pulmonary therapy at Oakwood Hospital has had his "Atlas of Critical Care Chest Roentgenography," published. Doctor Victor spent three years doing research. ... **Bertram Pitt, MD,** Ann Arbor, was named Chairman of the Young Investigators' Awards Committee. ... **Freeman M. Wilner, MD,** Troy, received the 1985 Wayne State University Medical Alumni Association Distinguished Alumnus Service Award. ... **Rodney J. Rohrich, MD,** Ann Arbor, was selected to serve as chairman of the Resident Physicians Section of the AMA. ... **William H. Salot, MD,** Grosse Pointe Farms, recently was appointed secretary of the board of directors of the American Academy of Orthopaedic Surgeons. ... **Michael F. Schaldenbrand, MD,** Detroit, recently became the 10,000th member of the College of American Pathologists. ... **Donald J. Shuman, MD,** was named president-elect of the Detroit Occupational Physicians' Association. ... **Ray A. Breitenbach, MD,** Pontiac, was awarded an American Academy of Family Physicians McNeil Award for clinical research by family practice residents.

... More than 400 Indians, including many MDs, attended a fundraising dinner for cancer victims of India to raise money for much needed medical equipment and drugs not available in their homeland. The event was sponsored by the Nargis Dutt Memorial Foundation, Michigan Chapter, an international organization, and by **Indian Medical Doctors in Michigan.** ☐

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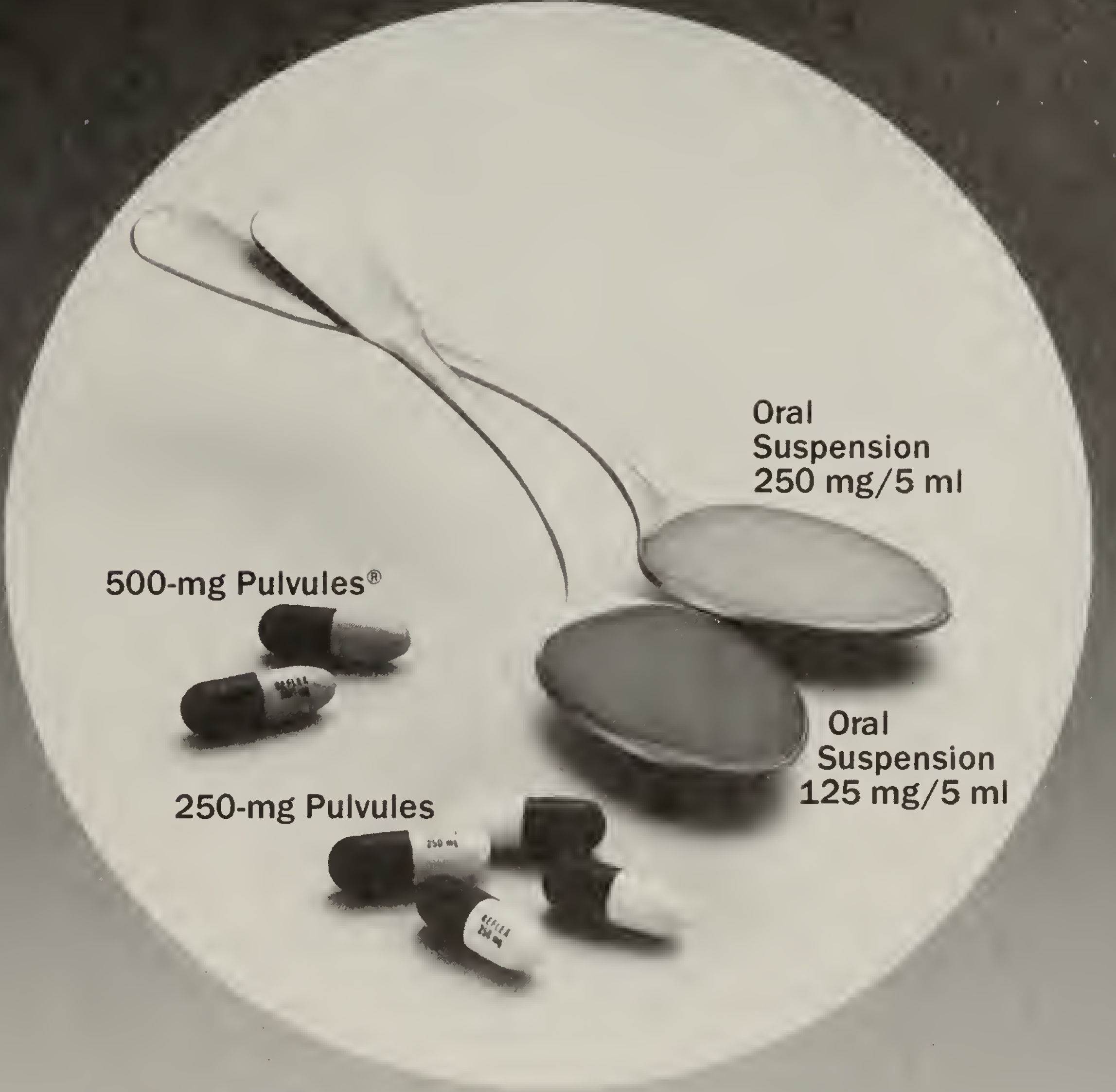
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DEATHS

Florence Ames, MD
Monroe
Doctor Ames died March 31 at the age of 89. She retired in 1971 after practicing for 45 years as a family physician. She received her medical degree from Rush Medical College at the University of Chicago in 1921.

Eli Coats, MD
Holland
Doctor Coats, 49, died April 19. He graduated from the Indiana University School of Medicine in 1965. He was a family practictioner specializing in industrial medicine. He graduated from Butler University School of Pharmacy in 1958 and from Indiana University Medical School in 1965. He did his internship at Marion County General Hospital in Indianapolis, and was Captain in the US Air Force Reserve.

Raymond Cook, MD
Bay City
Doctor Cook, 77, a retired physician since 1977, died March 17. He graduated from Wayne University Medical School in 1935 and practiced medicine for 22 years in Akron, Michigan. While there he served as president of the Tuscola County Medical Society. In 1960 he moved to Bay City and opened a practice which he maintained for 17 years.

Kenneth Gordon, MD
Flint
Doctor Gordon died April 13. He graduated from the University of Michigan Medical School in 1973. He specialized in internal medicine and was affiliated with McLaren General Hospital in Flint.

Arthur Hammond, MD
Detroit
Doctor Hammond died March 20. He was a physician, surgeon and dentist for nearly 50 years. Doctor Hammond was awarded a degree in dentistry from the University of Michigan in 1917 and a medical degree from Detroit College of Medicine in 1926. He practiced his specialty, otolaryngology, at Harper Hospital from 1926 until his retirement in 1975.

Allan R. McGregor, MD
Clio
Doctor McGregor, 54, died February 4. After graduating from the University of Michigan Medical School in 1957, he served in the US Public Health Service in Hinsdale, Illinois, and Little Rock, Arkansas. He moved back to the Flint area to practice in 1961, and spent many years working in the Indian Guides and other Scouting programs.

David McTaggart, MD
Gainesville, Florida
Doctor McTaggart, formerly of Flint, died January 26. He was 62. After graduating from the U-M Medical School with a specialty in internal medicine, he studied at Johns Hopkins University and Albion College. He served in the US Air Force for two years as a Captain. Doctor McTaggart was instrumental in developing the heart unit at St. Joseph Hospital, and practiced in Flint until his retirement in 1981.

Continued on page 410

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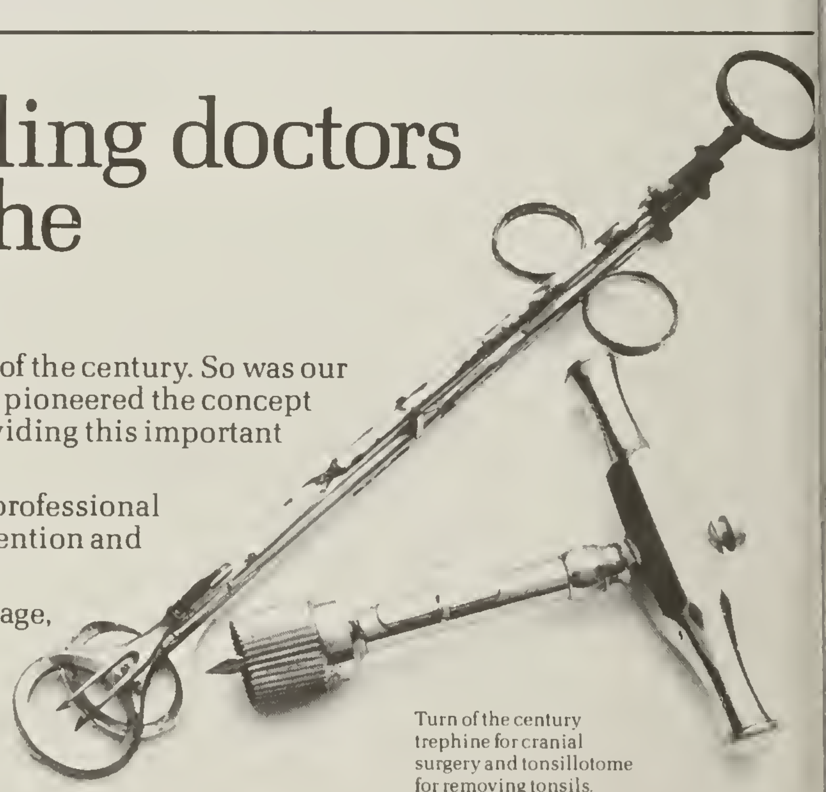

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Boxidar Momcilovich, MD
Flat Rock
Doctor Momcilovich, who had a private practice in Rockwood from 1957 until 1973, died April 9. He was 65. Doctor Momcilovich attended the University of Ottawa and graduated with an MD degree in 1955.

Herbert Pedersen, MD
Dearborn
Doctor Pedersen died March 28 at age 67. He was an orthopedic surgeon and retired Wayne State University Medical School department chairman. He was a 1941 graduate of the University of Michigan Medical School.

Jerome Pollack, MD
Allen Park
Doctor Pollack, a downriver surgeon for 27 years, died February 10 at the age of 59. He graduated from George Washington University and was awarded a fellowship in surgery at the Lahey Clinic in Boston. After moving to Allen Park, he was a staff physician at Lynn Hospital in Lincoln Park and past chief of staff of Seaway Hospital in Trenton.

Edward J. Prisbe, MD
Bloomfield Hills
Doctor Prisbe, 66, died April 23, 1984. He graduated from the Wayne State University College of Medicine and Surgery in 1942 and served as a flight surgeon in the US Navy during World War II. He was affiliated with Grace, Brent and Park General hospitals.

Benedetto Pugliese, MD
East Detroit
Doctor Pugliese died February 26 at the age of 87. He was born in Alcamo, Italy and graduated from the University of Palermo in 1921. He arrived in Detroit at the age of 23 and practiced surgery there for 55 years. He received an award from the Italian Government in 1965 for his work among Italian Americans. Doctor Pugliese was a founding member of Detroit Memorial Hospital.

R. A. Rivas, MD
West Bloomfield
Doctor Rivas died March 10 at the age of 73. Doctor Rivas graduated from Facultad de Medicine in Uruguay in 1940. He practiced general medicine at Pontiac General Hospital.

John D. Snider, MD
Grand Rapids
Doctor Snider, a former preceptor in anesthesiology at Blodgett Memorial Medical Center, died March 18 in Suther, Louisiana. He was 70. Doctor Snider was a 1939 graduate of Loma Linda University School of Medicine in Riverside, California.

Continued on page 412

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: July 15-17, Twelfth Michigan Emergency Medicine Assembly. Location: Grand Traverse Resort Village. **Sponsor:** Michigan Chapter American College of Emergency Physicians. **Contact:** Catherine C. Sleicher, American College of Emergency Physicians, 1305 Abbott Road, Suite 104, East Lansing, MI 48823, (517)332-6500. **Approved for:** 17 hours of Category I Credit.

Date: July 25-26, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684 (616)922-9544. **Approved for:** 9 hours of Category I Credit.

Date: July 25-26, Clinical Nutrition Update: Alternatives and Controversies in Nutrition Counseling. Location: Towsley Center. **Sponsors:** University of Michigan Medical School and University of Michigan Hospitals. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center - Box 057, UM Medical School, Ann Arbor 48109 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

Date: August 1-4, Level II Tutorial on Myofascial Release Technique. Location: The Homestead, Glen Arbor. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for: 21 hours of Category I Credit for MDs and DOs.**

Date: August 24-27, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center - Box 057, University of Michigan Medical School, Ann Arbor 48109 (313)763-1400. **Approved for:** 10 hours of Category I Credit.

Date: August 29-31, Controversies in Obstetrics and Gynecology. Location: Grand Hotel, Mackinac Island. **Sponsor:** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Washington, DC 20024. **Approved for:** 16 hours of Category I Credit.

Date: September 4-8, Tutorial on Fundamentals of Muscle Energy Diagnostic and Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: September 10, Lipid Disorders: Insights Into A New Era. Location: Ingham Medical Center, Lansing. **Sponsor:** Postgraduate Medicine Custom Communications. **Contact:** Mrs. Agnes Bauman, 1221 Avenue, 41st Floor, New York, New York 10020. **Approved for:** 7 hours of Category I Credit.

Date: September 11 - Cancer Detection & Management: The Role of the Primary Physician. Location: Civic Center, Marshall. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Continued on page 414

DEATHS/Continued

Hugh Stalker, MD
Grosse Pointe Farms
Doctor Stalker died April 5 at age 91. He graduated from Harvard University Medical School. Doctor Stalker was on staff at Harper and Children's hospitals in Detroit and Children's and Bon Secours hospitals in Grosse Pointe.

Godfrey Stobbe, MD
Detroit
Doctor Stobbe, 71, retired Detroit pathologist, died March 18. He was a 1939 graduate of the University of Michigan Medical School and was an associate and attending pathologist at Grace Hospital in Detroit from 1970 until his retirement in 1981.

Joseph Whinery, MD
Grand Rapids
Doctor Whinery died April 7 at age 80. Doctor Whinery graduated from the University of Michigan Medical School in 1929. He practiced internal medicine. Doctor Whinery was a past president of Kent County Medical Society.

Morris Wilderon, MD
Ada
Doctor Wilderon died March 29 at the age of 80. Doctor Wilderon was a former assistant director of the Kent County Public Health Department. He graduated from the University of Michigan Medical School in 1934.

Fredrick Williamson, MD
Ypsilanti
Doctor Williamson, who practiced surgery in Ypsilanti for 47 years, died April 23 at the age of 81. Doctor Williamson graduated from the University of Michigan Medical School in 1928.

Thomas Wilson, MD
Dunedin, Florida
Thomas Wilson, MD, a 1914 graduate of McGill Medical College, died March 12. He was 96.

George Winton, MD
Birmingham
Doctor Winton died January 24 at the age of 76. He attended Wayne State University College of Medicine. He was a 1935 graduate, and specialized in psychiatry.

Steven Zonnebelt, MD
Holland
Doctor Zonnebelt, died April 19. He graduated from John Hopkins Medical School in 1976 and completed his internship and residency in general and vascular surgery at the University of Wisconsin. He began his practice in Holland as a member of the Holland Surgical Associates in 1981.

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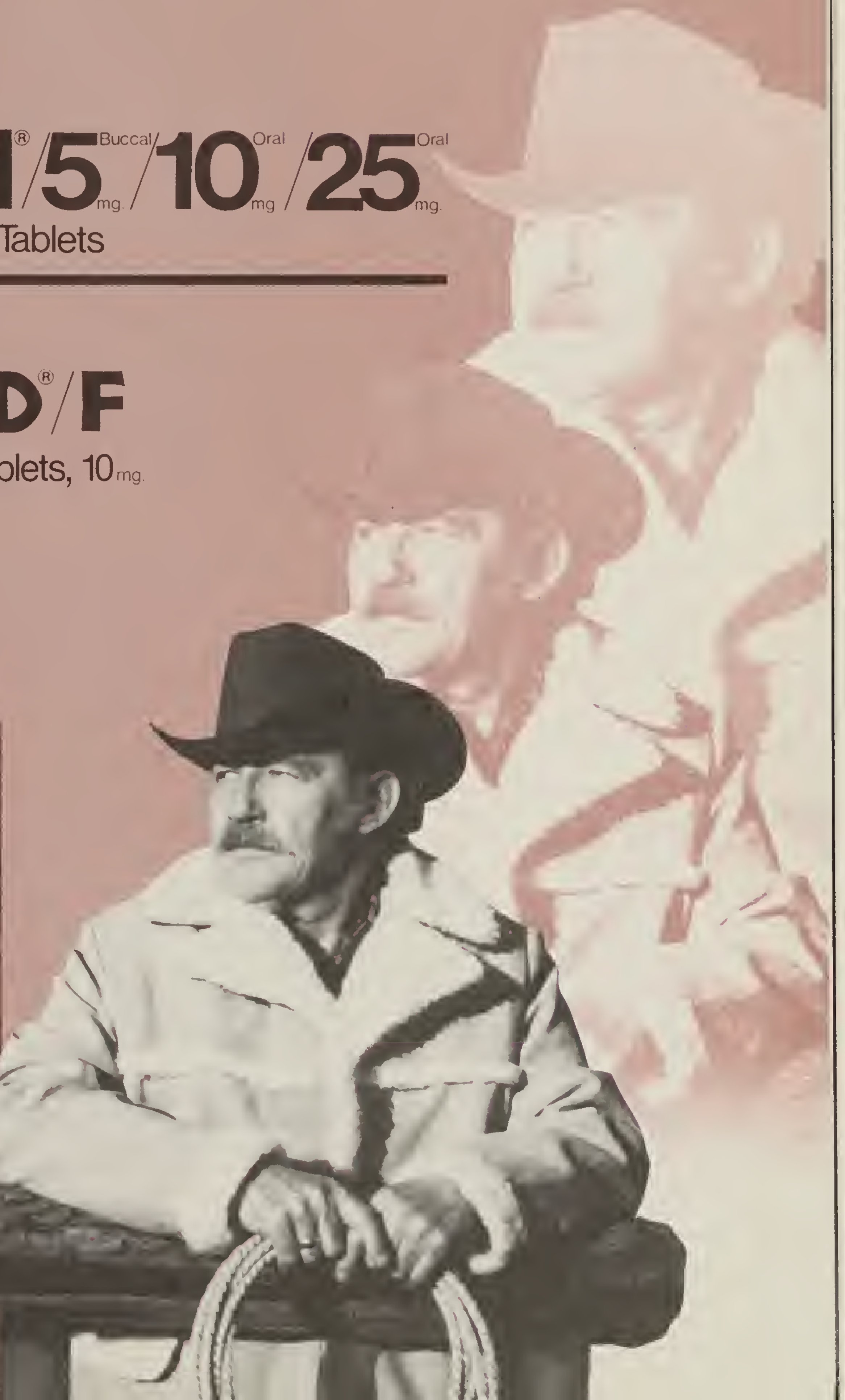

CATEGORY I/Continued

Date: September 16-18, Trauma to the Hand: Diagnosis, Treatment and Functional Restoration. Location: Towsley Center. **Sponsor:** American Society for Surgery of the Hand. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, CO 80014, (313)755-4588. **Approved for:** 16.5 hours of Category I Credit.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 20, Reflections on Suicide and Suicide Prevention Location: Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Western Michigan Psychological Association **Contact:** Nancy Petty, PD (616) 966-5600, ext. 3594. **Approved for:** 6 hours of Category I Credit.

Date: September 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Colorado 80014. (303)755-4588. **Approved for:** 18 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295. **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 29-October 1, Tutorial on Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Human Medicine and Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: October 4, 6th Annual Trauma Day. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Bronson Methodist Hospital and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar Bouma (616)383-7576. **Approved for:** 7 hours of Category I Credit.

Date: October 4, Early Revascularization in Acute Myocardial Infarction. Location: Borgess Medical Center Auditorium. **Sponsor:** American Academy of Family Physicians, Kalamazoo Chapter of the Michigan Heart Association and Southwestern Michigan Area Health Education Center. **Contact:** Sharon Nocera (616)383-5940. **Approved for:** 6 hours of Category I Credit.

Date: October 4-6, Technological Advances and the Anesthesiologist. Location: Amway Grand Plaza, Grand Rapids. **Sponsors:** Michigan Society of Anesthesiologists and University of Michigan Department of Anesthesia. **Contact:** Caroline Rich, MSMS Headquarters, East Lansing. **Approved for:** 7 hours of Category I Credit.

Date: October 5-6, The Geriatrics Challenge/The Medical Response. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic. **Contact:** Kay Kelly, (616)383-4500. **Approved for:** 12 hours of Category I Credit.

Date: October 7-11, Tutorial and Workshop in the use of Immunocythochemistry and Electron Microscopy in Tumor Diagnosis. Location: Engineering Society of Detroit. **Sponsor:** MSMS and Michigan Cancer Foundation. **Contact:** Jose Russo, MD, Michigan Cancer Foundation, 110 East Warren Avenue, Detroit 48201 (313)883-0710. **Approved for:** 44 hours of Category I Credit.

Date: October 11-13, Infectious Diseases "Hands-on Pelvic Workshop." Location: Grand Traverse Resort. **Sponsor:** MCAAP Committee on Adolescence and OMNI Corporation. **Contact:** Natalia M. Tanner, MD, 4727 St. Antoine, Hudshell Building, Suite 303, Detroit 48201. (313)831-1300. **Approved for:** 8 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 20 hours of Category I Credit.

Date: October 11-13, An Affordable Prescription: Knowledge, Comradery, and Relaxation. Location: Grand Traverse Resort. **Sponsor:** American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 19, Common Problems with Coronary Artery Disease. Location: Somerset Inn. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076 (313)557-9500. **Approved for:** 7 hours of Category I Credit.

Date: October 21-25, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: October 23, The Second Annual Conference on Alcholism. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo. **Approved for:** 6 hours of Category I Credit.

Date: November 2, Women Current Psychoanalytic Views. Location: Hyatt Regency, Dearborn. **Contact:** Deanna Holtzman, PhD, Chairman, 16310 West Twelve Mile Road, Suite 204, Southfield 48075. (313)557-8633. **Approved for:** 6 hours of Category I Credit.

Date: November 7, Michigan Family Practice Research Day IX. Location: Michigan State University. **Sponsor:** Michigan State Family Practice. **Contact:** Douglas B. McKeag, MD, Chairman, B-100 Clinical Center, MSU, East Lansing 48824. (517)353-0770. **Approved for:** 10 hours of Category I Credit.

Date: November 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. 18 Category I Credits applied for.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 23-25, Tutorial on Fundamental Principles of Manual Medicine as Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: December 2-6, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit.

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

July 18-20 — MSMS Board of Directors Midsummer Meeting, Hidden Valley Resort, Gaylord, contact: William Madigan, MSMS headquarters.

September 18-19 — AMA 1985 Political Education Conference, Washington, DC, contact: AMA Division of Political Education, 1101 Vermont Avenue, NW, Washington, DC 20005. (202)842-8442.

October 17-19 — AMA National Medical Staff Conference, Sheraton Washington Hotel, Washington, DC, contact: Karen Prupes, (312)645-4418.

OTHER MEETINGS

July 24 — Michigan Chapter, American Council of Surgeons - Council, Park Place Hotel, Traverse City, contact: Viola M. Heins, (517)337-1351.

July 24 — Michigan Psychiatric Society Council Meeting, Inn on the Park, Toronto, contact: Michigan Psychiatric Society, 21700 Northwestern Highway, Suite 1175, Southfield 48075.

August 2-4 — Summer Seminar Michigan Medical Assistants, Hyatt Regency, Flint, contact: Michigan Medical Assistant Journal, 6724 Cooper, Lansing 48910.

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313)839-3011.

September 9-11 — Promoting Family Planning: One Voice; One Goal, Ponchartrain Hotel, Detroit contact: Family Planning Office, MDPH, (517)373-6790.

September 18 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola M. Heins (517)337-1351.

October 6 — Fall Brunch Meeting of Physicians of India, Troy Hilton contact: Doctor Kothari (313)644-1269.

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CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

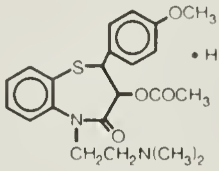
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-8enzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Oiltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CAROIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CAROIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CAROIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CAROIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm**. CAROIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CAROIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CAROIZEM is indicated in the management of chronic stable angina. CAROIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CAROIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CAROIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CAROIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CAROIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CAROIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CAROIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CAROIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CAROIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted.

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CAROIZEM.

The following postmarketing events have been reported infrequently in patients receiving CAROIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LOH, and CPK. However, a definitive cause and effect between these events and CAROIZEM therapy is yet to be established

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CAROIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LO_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LO_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CAROIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CAROIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

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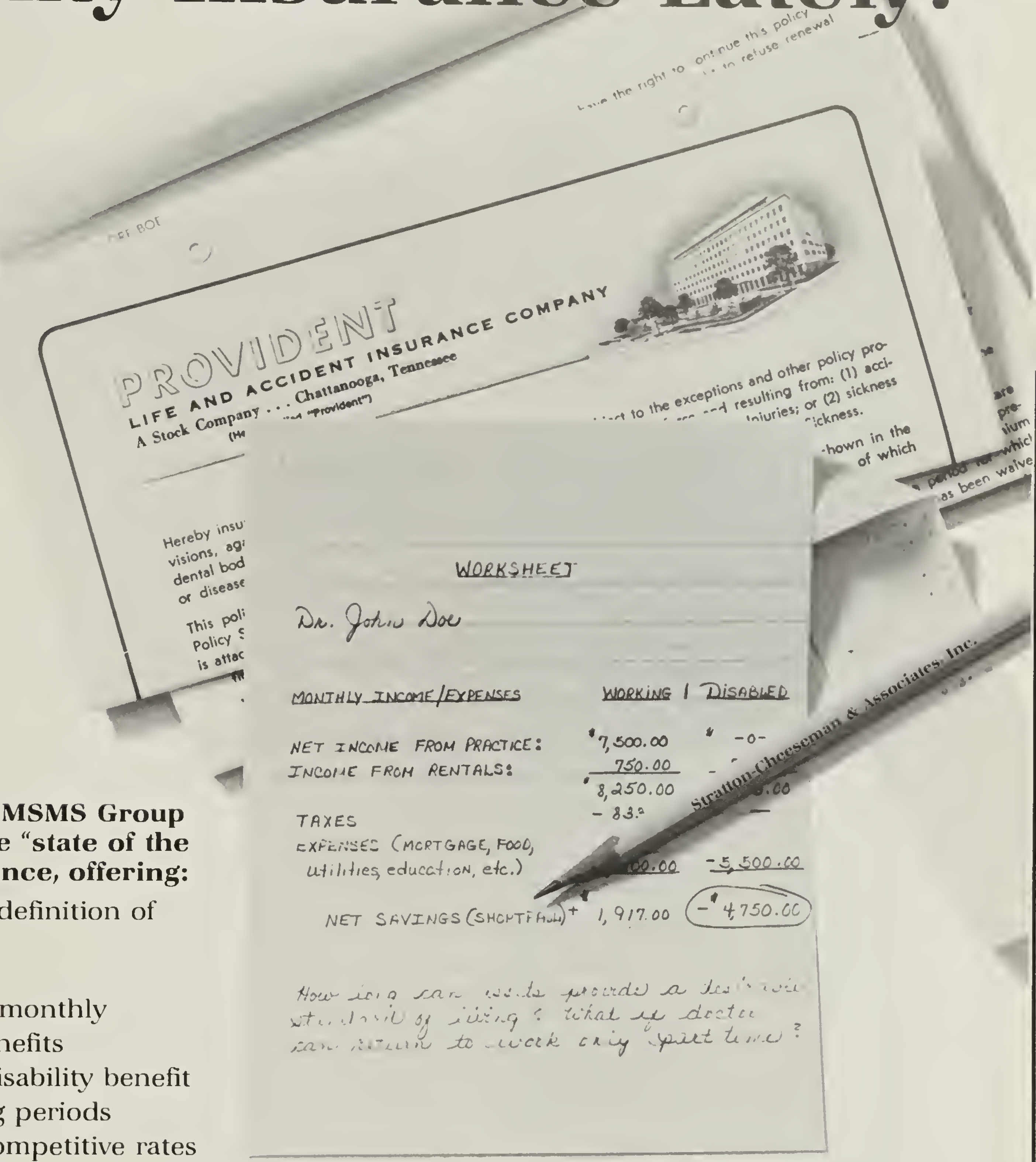

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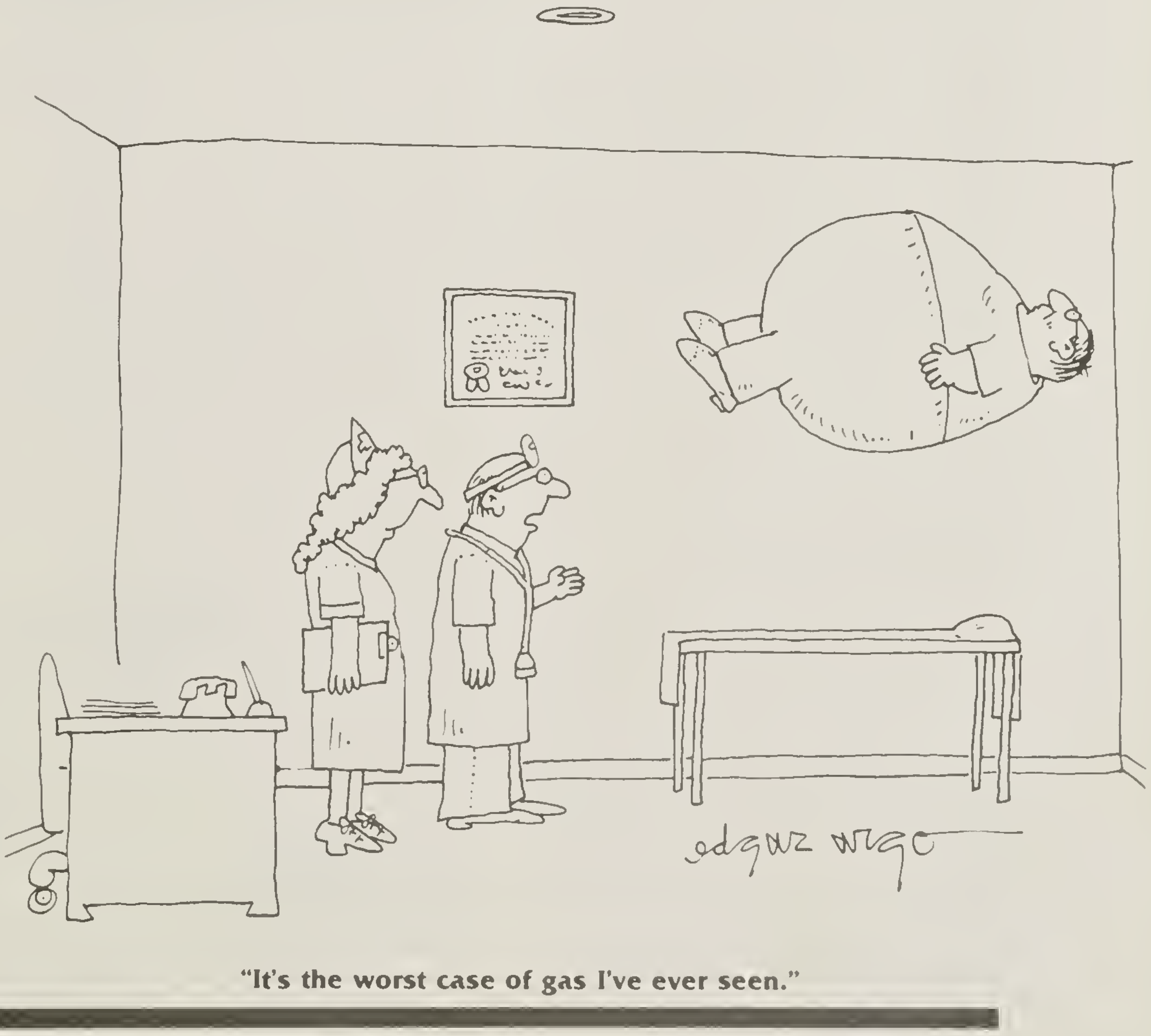

"It's the worst case of gas I've ever seen."

By Richard J. McMurray, MD

Organized medicine staying relevant for the times

The following is the second in a two-part series of articles taken from the address delivered by Doctor McMurray when he was installed April 27, as MSMS president. In the first installment, Doctor McMurray closed with the call for physicians to maintain strength in their organizations.

The suit filed by the AMA in Federal Court over the Medicare fee freeze is an example of how we can set policies and principles to meet our patients' needs. The voluntary effort of the AMA members to hold fees has reportedly saved patients $1.5 billion. The voluntary commitment is working. On the other hand, mandatory govermental assignment will force a two-tier system of medicine, actually denying the patient's right to select his or her own physician. Your national organization is making every attempt to prohibit this—not for the benefit of physicians, but for the benefit of the Medicare population. Again, we as an organization present ourselves as *the advocate for our patients*.

There are other changes occurring in medical practice. For example medical liability and its threat to render certain specialists unable to afford to deliver medical care. Your AMA and MSMS are making concerted efforts to develop alleviation programs—back your organization in these efforts. But protect yourself by giving your patients the best care you can, and keep complete and timely records that identify your clinical reasons and judgments. Do not hesitate to seek consultation, both with your colleagues and with the patient and family. This will go a long way toward establishing a non-litigious rapport with your patients, and to avoid a confrontation with some plaintiff's attorney.

Tort reform plans

New malpractice reforms will be submitted to the state and national legislative bodies in the coming year. I submit that if legislators are really serious about cost containment, they will take some definitive action in the area of tort reform.

In 1985 we physicians are struggling to find our place in new surroundings, which are competitive, demanding and unstable. We must not allow this new world to divide our profession into groups of physicians who are in conflict with one another. Regardless of the type of practice system we individually commit ourselves to, we must all maintain our commitment to preserving excellence in the delivery of medical care.

Striving for relevance

It is our challenge, as leaders of medical associations at the county, state and federal levels, and in state and national specialty societies, to see to it that our organizations are relevant for the times.

What do I mean by relevant? Relevance means that in the ambience of the mid-1980s the medical practitioner must be more than ever before the advocate for the patient, and for quality medical care. It means somehow interlacing the hard facts of the new medical economics with the best of the old, aspiring for effective and efficient medical treatment.

We as a medical association are now engaged in a project to address these issues. The American Medical Association is well down the road in developing, with a variety of other groups, a national health policy agenda. MSMS members have been involved in creating this new agenda. Doctor Susan Adelman, Doctor Donald Crandall, Doctor Jim Potchen and others are personally working to achieve this lofty goal.☐

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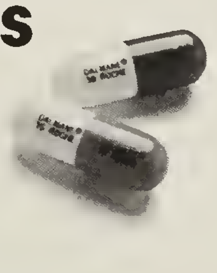

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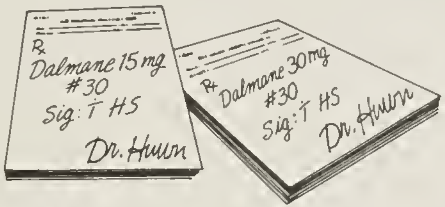

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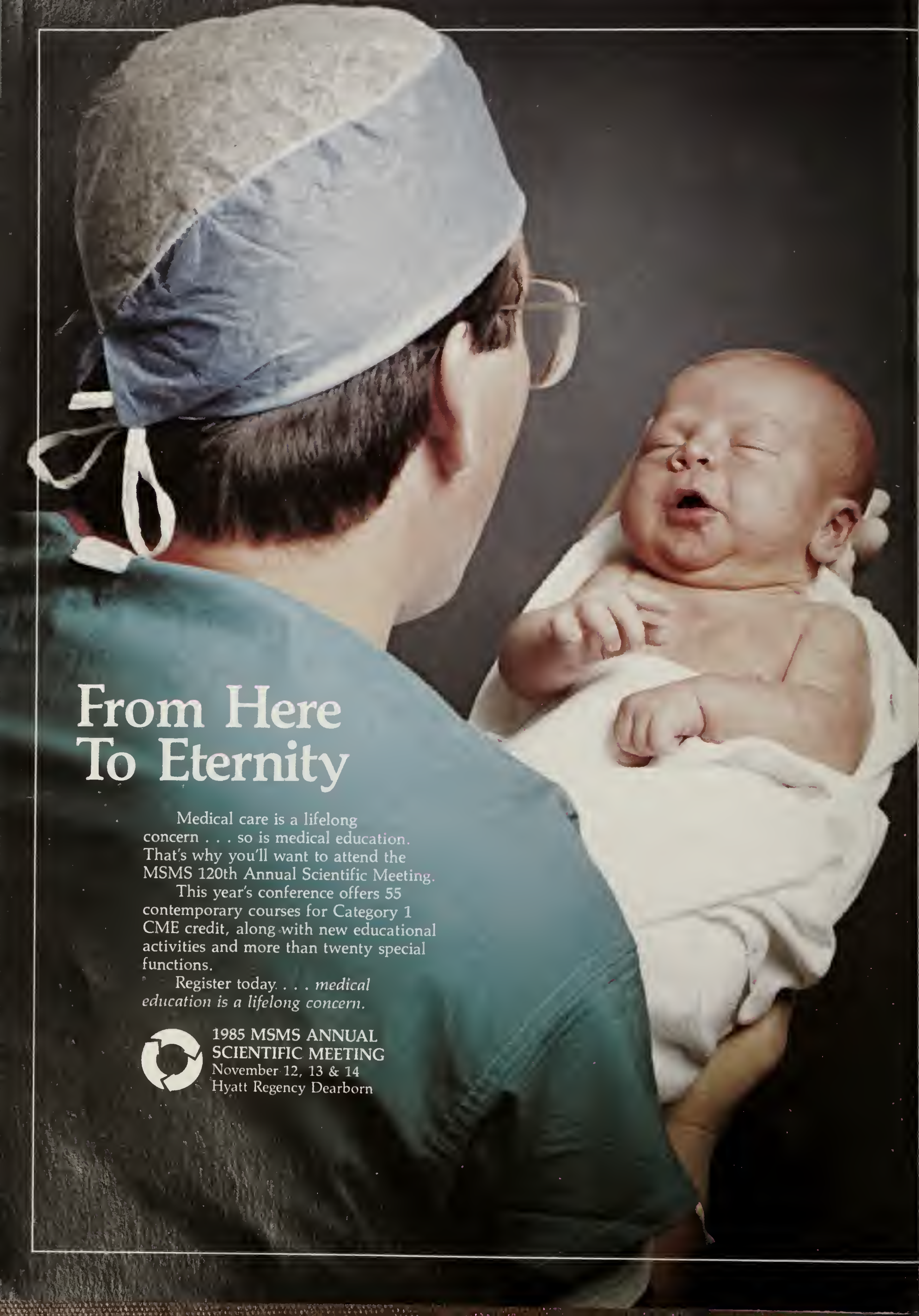

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MICHIGAN MEDICINE

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She's counting on you —
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About the cover: There is a lot riding on the well-being of a physician: The well-being of the doctor's patients tops the list. Photo by Kim Kauffman

Special report

424 The MSMS Program to Assist Impaired Physicians, infused with large doses of enthusiasm and energy, has grown noticeably in the past year. Program Chairman Carl A. Gagliardi, MD, predicts that new developments will bring aid to even more physicians who need it. Articles in this special report describe current MSMS efforts to reach out to impaired physicians, highlights of the upcoming Conference on the Well-being of Physicians, an overview of similar efforts across the country, suggested hospital bylaw wording regarding impaired physician review, and stress and impairment among medical students: Carole Eberly; Judy Marr; Robert Niccolini, MD, and Jane Thomas, PhD; Mike Potchen, and Richard D. Weber, JD.

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478 President's page: Come to Lansing October 22 show lawmakers the crisis is real; Richard J. McMurray, MD

In next month's issue of Michigan Medicine: Courses at this year's Annual Scientific Meeting will study diabetes and pulmonary disease "From Here to Eternity," or from childhood through the late years. There will be a lot of new offerings at this year's meeting — read about them in the September issue.

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Seat belt exemption questions

I read in the June 6 *Medigram* your article about physician risk ability exposure with seat belt waivers. The problem I have been aced with is not patients who should not wear a seat belt because of the medical condition, but rather patients who are unable to hook the seat belt together and therefore cannot connect the seat belt because of arthritis. These individuals are able to drive short distances and may be able to be independent given a small amount of driving. However, they are not capable of hooking up the seat belt and have asked me for an exemption for that reason.

Has the legal counsel considered this issue and what is their advice regarding this issue?

Kenneth A. Weinberger, MD
Warren

Richard D. Weber, JD, of Kerr, Russell and Weber, Detroit, MSMS legal counsel, responds: The new seat belt law has generated considerable interest among physicians, particularly with respect to the statutory exemption. I authored an article published in the July edition of Michigan Medicine. I recommend that article for your reading. It illustrates the legal dilemma confronting physicians when a patient requests a "prescription" for the exemption.

The statutory exemption provides as follows:

> "This section shall not apply to a driver or passenger of: (e) a motor vehicle if the driver or passenger possesses a written verification from a physician that the driver on passenger is unable to wear a safety belt for physical or medical reasons."

The initial issue posed in your letter is whether the exemption applies to a patient who is "unable to hook the seat belt together", as opposed to a patient who cannot wear the seat belt for "physical or medical reasons". Literally interpreted, the statutory exemption would only apply to the patient who is unable to wear a safty belt for physical or medical reasons. If the patient can wear the belt but is unable to hook it up, it is conceivable that a court could interpret the statutory exemption as inapplicable.

If there is such a patient who simply cannot hook up the seat belt, perhaps this problem can be solved by some adjustment to the seat belt so that the hookup mechanism is in the right place. In addition, perhaps the patient could have another person hook up the belt. Such suggestions may provide some inconvenience, but inconvenience is no reason to trigger the statutory exemption.

Whether a patient is unable to wear a safety belt for physical or medical reasons is obviously a decision that must be made by the physician. I have been advised by a number of physicians that there simply is no physical or medical reason which would justify not wearing a safety belt. Whether this is true or not, it is clear from a legal standpoint that the physician assumes a certain degree of legal risk if such a written verification is given. In this limited instance, I have suggested in my article a proposed procedure to follow. This includes a short statement to be signed by the patient.

I hope my comments and article will assist you in making your decision in the unique case of arthritic patients.

Mike Strepp

"Unfortunately, your insurance will only let us REPAIR your appendix."

By Judy Marr, Editor

Helping impaired physicians the goal of MSMS program

Carl A. Gagliardi

A year ago, the chairman of the MSMS Impaired Physicians Program was ready to give up his position.

"I felt I had done all I could do," remembers Carl A. Gagliardi, MD, Dearborn pediatrician and chairman of the MSMS Board of Directors.

Then he attended the Second Annual Conference on the Well-Being of Physicians sponsored by the Impaired Physicians Program, and met "a whole bunch of people who said there was lots to be done."

So, he renewed his enthusiasm and began a year which has seen major growth in the 12-year-old program. A push began at that conference in September, 1984, for a statewide diversion program for physicians who abuse drugs and/or alcohol, or who have other physical or mental impairments. The conference opened the doors for a full-time, paid, professional staff person for the program, and initiated promotion of impaired physician committees in hospitals.

When Doctor Gagliardi became chairman of the program in 1981, he worked hard to promote it. Of course, one of the major activities he heads to accomplish that goal is the annual Conference for the Well-Being of Physicians.

Another early effort was with the Michigan Association of Osteopathic Physicians and Surgeons, which sought help in developing a program.

"We offered to help them or to welcome them to our program. They chose the latter option and we think the association has been worthwhile. There is a lot more we can do together."

Still another major effort was to urge the Michigan Foundation for Medical and Health Education to establish a loan fund for impaired physicians. Since its special fund was established in 1983, the Foundation has loaned nearly $24,000 to help physicians meet personal and family obligations while under treatment.

A history of aid

In 1984, the MSMS Impaired Physician Program received 42 calls for aid. Some came from physicians, some from persons close to them who requested help for colleagues or family friends.

"We suspect the incidence of drug and alcohol abuse among the physician population is no different than among the rest of the population," says Doctor Gagliardi.

"We are not getting to as many as we should. We hope our new developments — full time professional director, more volunteers, grassroots structure and greater confidentiality—will bring out more physicians who need aid.

"Then the public will be better protected, too."

These developments are planned:

The diversion program. Physicians reported to the Board of Medicine would be interviewed and screened for their potential for recovery. If the potential is high, they would be referred to the MSMS Impaired Physician Program. It would assume responsibility for assigning physicians to a treatment regimen, for following them through the process, and for notifying the Board when they are ready to return to active community involvement.

"The point is to separate those who are sick and treat them for their illness," explains Doctor Gagliardi.

"We wouldn't abandon a diabetic because he had a bad case of the disease. In the same way, we do not intend to abandon impaired physicians — particularly because the outcome can be so favorable."

Protecting the public

In no way do the program leaders want to injure the public, assures Doctor Gagliardi.

"If a person is involved in drug trafficking or anything of that sort, then obviously that is a legal matter. We're not talking of taking them out of the legal arena."

The program would be accountable to the Board of Medicine, emphasizes Doctor Gagliardi. "We would be expected to be sure that the indi-

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vidual was following a program, and doing whatever necessary to ensure they were recovering.

"Obviously, if the individual did not show improvement, was not cooperating as we felt they should, then the Board would have to take them back.

"By conducting the program in a confidential manner, and always keeping in mind the public's protection, I believe we would have the greatest chance of success," he says.

Other benefits

Doctor Gagliardi believes that such a diversion program would help the Board "by taking some obviously medical problems off their hands and proceeding to solve some of the problems with good therapy rather than court battles."

Also, he says, it would help hospitals "by more readily identifying persons who need help and by getting them out of a position where they may have some potential for causing harm."

Doctor Gagliardi believes in the program, he says, because "the success rate is tremendous" in other states with similar organizations.

Paid professional director. Following the lead of other state societies, MSMS seeks a full-time, paid, professional director, to manage the program and to supervise individual physicians' therapy.

The MSMS House of Delegates in April supported this goal by voting to seek funds to hire a trained physician. Program leaders will make grant applications in the near future.

Hospital impaired physician committees. The MSMS program wants to get hospital medical staffs around the state involved because, says Doctor Gagliardi, "one of the big problems with helping impaired physicians in the past was that if a person sought help in his hospital he would be reported to the Board.

"We would like to see hospital bylaws amended," he continues, "so that impaired physician activities would become part of the peer review process. The materials uncovered by hospital peer review committees, of course, are not discoverable in legal situations." (See related bylaws article in this Special Report.)

In addition, he says, the program likes to treat individuals near their homes and to get them back in the mainstream as soon as possible.

One of "the most exciting" things, says Doctor Gagliardi, is that other health care professionals are interested in joining the program to help their own. Dentists and pharmacists have inquired.

"Nurses are another group under considerable stress who may have problems and could benefit," he says. "I visualize bringing them into the program if they choose to join it.

"I said once to a hospital administrator, not in jest," says Doctor Gagliardi, "that we might be willing to include hospital administrators who may need the help."

Doctor Gagliardi says he will continue as chairman "until some of what we want to accomplish is done.

"It takes time to really understand the political, medical and legal arenas," he says, "so I can't abandon the program now."

Progress timetable

The timetable for developing the expanded impaired physicians program calls for program leaders to meet with the Board of Medicine and the director of the Michigan Department of Licensing and Regulation soon to seek support for the diversion program. Doctor Gagliardi already has met informally with Ray Hood, L & R director.

Program leaders also are consulting other state societies with diversion programs to avoid pitfalls. "If we're going to provide close supervision of impaired physicians we have to be prepared," emphasizes Doctor Gagliardi.

He urges every county medical society to send representatives to the September Conference on the Well Being of Physicians, September 20-22 at the Amway Grand Plaza, Grand Rapids. "This program is one of the humanitarian efforts of this society," says Doctor Gagliardi. "The only goal is to help our colleagues.

"There's nothing else in it for us."☐

By Russell F. Smith, MD

Highlights of the upcoming conference on impaired doctors

The Third Annual Conference on the Well-Being of Physician will be held September 20-21-22 at the Amway Grand Plaza Hotel, in Grand Rapids. These conferences bring together those concerned about physicians with stigmatized illnesses.

Michigan, as well as most of the United States and Canada, has been rethinking its role in this area. In the past we have categorized serious illness as a moral matter. We have punished physicians who needed medical help.

The Conference this year will deal with practices and procedures of our state, hospitals, clinics, HMOs, and PPOs involved in this care. We will attempt to develop a better and more humanitarian approach to the problems developed.

This conference will be a valuable learning experience for those who deal with physicians with stigmatized illness. It will be equally as valuable to those whose responsibility it is to implement quality controls affecting physician colleagues. Together, those who must deal with chemically or psychologically impaired physicians and the physicians recovering from these diseases, can develop new solutions to old and vexing problems.

Doctor Smith is program chairman, Michigan Conference on Well-Being of Physicians.

By Carole Eberly

Programs to aid troubled MDs vary across the country

Impaired physician programs are more than window-dressing for a problem that has been attacked head-on by state medical societies.

Flexibility, confidentiality and tight monitoring is the common glue among them. After that, the programs are as varied as the geographic regions they cover.

In Oregon, for instance, dentists, as well as physicians, are welcome in the program. The New Jersey Veterinary Medical Association has joined forces with the Medical Society of New Jersey's Impaired Physician Program to help its members. The Medical Society of New Jersey also has created AIMS (Assisting Impaired Medical Students).

Although most programs define "impaired" as involving drug or alchohol abuse or psychiatric disorders, at least one — in New Jersey — also provides help for physicians suffering from senility.

"It's ironic that one of the founders of Alcoholics Anonymous was 'Doctor Bob,' a practicing proctologist in Akron, Ohio," Richard Bates, MD, of Lansing wrote in an article for *Medical Economics*. "Why? Because nearly 50 years later physicians still don't recognize that up to 90 percent of our addicted colleagues can recover from alcoholism or drug dependence."

Early detection

Delaying help and recovery is the realization that many impaired physicians are unaware of their problem.

"Effective treatment for the disorders which lead to physician impairment is most easily achieved when the disease is detected early," literature from the Medical Society of New Jersey states. "Family, friends and associates of impaired physicians should avoid misguided sympathy which enables the condition to deteriorate."

New Jersey is developing a panel of intervenors throughout the state.

"Historically, most of the other state committees have found that a team of confronters seem to be more effective than a solitary confronter," said a report on New Jersey's program.

A panel of intervenors in that state would assist in identifying impaired colleagues, participate in accumulation of necessary information to document the impairment, participate in the confrontation and assist in monitoring and follow up.

Many states, such as New York, have a hotline for referrals from friends, family, physician colleagues, hospital administrators, nurses and health care workers as well as for self-referrals. The New York State Health Department Office for Professional Medical Conduct may also refer impaired physicians to the program.

"The (Physicians) Committee's assistance in achieving recovery can be instrumental in these circumstances in preserving the physician's medical license," the Medical Society of the State of New York reported.

Self-referrals

A combination of a tough stance, the threat of state intervention, workable rehabilitative programs, and compassion may

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Ms. Eberly is a Lansing-area freelance writer.

be leading more and more physicians to seek help on their own.

In California, during the program's second year 75 percent of the physicians were self-referrals. However, New Jersey reported during a 24-month period (1982-84) about 18 percent were self-referrals, while almost 53 percent were colleague-referrals.

But perhaps even more important to the success of such programs in the guarantee of confidentiality.

"This ironclad confidentiality encouages sick physicians to come out of hiding," a report on the California Medical Association's program said. "All information gathered by the DEC (Diversion Evaluation Committee) and the program manager's staff remains undiscoverable, even by the BMQA (Board of Medical Quality Assurance, the state licencing agency) itself. On completion of the rehabilitation program, the DEC's records are destroyed."

The Oregon Medical Association pledged full confidentiality to completely and absolutely protect the anonymity of participating physicians.

"While demographic information will be maintained, no information will be kept which could lead to the identity of a given individual," an OMA report said.

Who is involved?

What about demographics? Who is being treated in these programs?

Again, the figures and percentages vary from state to state. However, family practice physicians and general practitioners are at the top of the list in many states, with physicians involved in internal medical running a close second. At the lower end of the scale were allergists, dermatologists, urologists, pathologists and radiologists.

Drug abuse accounted for about 44 percent of the California cases in 1983, while alcohol abuse was the problem in 28 percent. Alcohol *and* drug abuse was 13 percent and mental illness accounted for eight percent of the cases.

In New Jersey, alcohol abuse accounted for 26 percent of the impaired physicians, while drug abuse was at 20 percent. Psychiatric disorders were placed at almost 18 percent.

Demerol and cocaine were the most abused drugs by physicians in the California program.

The highest percentages by age group in the New Jersey program were 15.5 percent 31-35 years old; 13.2 percent 51-55 years old, and 12 percent for both 36-40 and 56-60 years old.

About five percent of participants were women.

"One of the reasons for this low number appears to be that in the age groups of the majority of our clients, there are a relatively small percentage of women physicians," the New Jersey report said. "It is expected that as the more recent medical school admissions and graduates will include much higher percentages of women, that the number served by our program will increase. Additionally, the cover-up of the female substance abuser may play a minor role in the low female incidence."

Effective monitoring

But no matter how good statistical reporting is and how advanced such items as hotlines are, the programs are only as good as their treatment and monitoring.

In New York, each participant may have one or more monitors selected.

"This monitor would be, optimally, an interested colleague in a position to observe the physician's behavior and performance," a New York report said. "In some instances, monitors may meet regularly and formally with the physician and submit a brief monthly report to the program. The monitor is separate from the treatment provider. He must be willing to request random urine specimens for drug screening and/or other tests as appropriate and to report any problems observed."

Participants are required to remain in the program for at least two years. Treatment providers are asked to document attendance and cooperation with treatment. Participants must keep a record of attendance at self-help and peer support group meetings.

In Oregon each participant is asked to sign a contract outlining the details of his or her specific treatment. Compliance is expected of all participants, whether voluntary or mandated, 100 percent of the time. Chemical monitoring of blood and urine specimens is done both regularly and randomly. Each participant has a regular personal physician who oversees his or her progress.

"We believe that a firm, well-managed, consistent, and carefully monitored treatment program will significantly assist in the rehabilitation of the recovering physicians," said Kent E. Neff, MD, Medical Director of the Oregon Monitored Treatment Program.

He said the program is designed to provide appropriate, long-term treatment "which is carefully and regularly monitored by both observational and chemical means."

And just how successful are these programs?

A report from David I. Canavan, MD, of the Medical Society of New Jersey said it is too early to tell.

"In three to four years, when we have had the time to accumulate several hundred cases, we will be in a much better position to review our data and draw some valid conclusions," he said.

"So far, our results have more than exceeded our expectations. We will be delighted if our present monentum continues. We would be happy to offer assistance to any other state medical society that would like to follow our lead.

"There are lots of suffering colleagues out there who need the assistance that this kind of program can bring," he concluded. "It is time that all of us make our best effort."□

By Richard D. Weber, JD

Legal counsel suggests bylaw wording to protect impaired physician review process

The MSMS Steering Committee on the Program to Assist Impaired Physicians recently asked MSMS legal counsel Kerr, Russell and Weber, Detroit, to prepare a bylaw for hospitals designed to bring impaired physicians under the hospital peer review committee functions. The purpose of this objective is to protect the impaired physician review process under the immunity and confidentiality statutes.

First, it is important to review the three applicable statutes:

* MCLA 331.531 through 331.533 provides as follows:

331.531 Data relating to physical or psychological condition and health care; review entity defined; liability

Sec. 1. A person, organization, or entity may provide information or data relating to the physical or psychological condition of any person, or the necessity, appropriateness, or the quality of health care rendered to any person, to any review entity. Review entity means a duly appointed peer review committee of the state, of a state or county association of health care professionals, of an officially constituted health care facility, or of a health care association; a professional standards review organization qualified under federal or state law; a foundation or organization acting pursuant to the approval of a state or county association of health care professionals; or a state department or agency whose jurisdiction encompasses such information. Liability of any kind shall not arise or be enforced against any person, organization, or entity by reason of having provided such information or data; by reason of any act or communication within its scope as a review entity; or by reason of having released or published the proceedings, reports, findings, or conclusions of the review entity subject to the limitations of sections 2 and 3. The immunity in this section shall not apply to a person, organization, or entity that acts with malice.

331.532 Release or publication of review entity reports, purposes

Sec. 2. The release or publication of the proceedings, reports, findings, and conclusions of a review entity shall be for one or more of the following purposes;
(a) To advance health care research or health care education.
(b) To maintain the standards of the health care professions.
(c) To protect the financial integrity of any governmentally funded program.
(d) To provide evidence relating to the ethics or discipline of a health care provider, entity, or practitioner.

331.533 Confidentiality, identity of person, proceedings and reports of review entity

Sec. 3. The identity of any person whose condition or treatment has been studied shall be confidential and such person's name and address shall be removed from the record before the review entity releases or publishes its proceedings, reports, findings and conclusions, and, except for the purposes set forth in Section 2, all proceedings, reports, findings and conclusions of review entities under this act are confidential and

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Mr. Weber is an attorney with MSMS legal counsel, Kerr, Russell and Weber, Detroit.

BYLAWS/Continued

shall not be discoverable or used as evidence in an action for personal injuries based upon malpractice, lack of informed consent or negligence.

Part 201 of the General Provisions relating to facilities and agencies under the Public Health Code has a confidentiality provision. MCLA 333.20175(5) provides as follows:

* "The records, data, and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena."

Part 215 of the Public Health Code, relating specifically to hospitals, has a similar provision. MCLA 333.21515 provides as follows:

* "The records, data, and knowledge collected for or by individuals or committees assigned a review function described in this article are confidential and shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena."

Bylaws review

I have reviewed the bylaws of a number of hospitals. Frankly, it is rare to find a separate peer review committee, or a committee that deals specifically with impaired physicians. Apparently, we are treading on new ground. Some bylaws impose professional review functions on a multitude of committees. Others are silent on the issue. It is probable that an individual hospital would want to draft the immunity and confidentiality provisions in a different way, depending upon the approach it has taken in this regard. Nevertheless, I have drafted and set forth herein some suggested language that might be used in whole or in part by a particular hospital. If nothing else, the following language will provide food for further thought and dialogue:

The PEER REVIEW COMMITTEE shall provide an ongoing review of professional practices at the hospital and shall include the review of physicians who may be impaired as a result of alcohol or substance abuse.

The PEER REVIEW COMMITTEE shall consist of physicians selected by the (excutive committee). Committee members shall select a chairman by majority vote and the chairman and members of the committee shall serve for one year. Members may be reappointed for subsequent years by the (executive committee).

The PEER REVIEW COMMITTEE shall receive information and data relating to the physical and psychological condition of any person, or the necessity, appropriateness, or the quality of health care rendered to any person. To the extent permitted by law, liability of any kind shall not arise or be enforced against any person, organization, or entity by reason of having provided such information or data; by reason of any act or communication within the scope of the PEER REVIEW COMMITTEE; or by reason of having released or published the proceedings, reports, findings, or conclusions of the review entity, so long as such release or publication is for one or more of the following purposes: (a) to advance health care research or health care education; (b) to maintain the standards of the health care professions; (c) to protect the financial integrity of any governmentally funded program; (d) to provide evidence relating to the ethics or discipline of a health care provider, entity or practitioner. MCLA 331.531.

All proceedings, reports, findings and conclusions of the PEER REVIEW COMMITTEE are confidential and shall be used only for the purpose of carrying out such functions. Such records, data and knowledge are not public records, are not subject to court subpoena and are confidential and entitled to all the protections set forth in MCLA 331.533, MCLA 333.20175 and MCLA 333.21515.☐

SPECIAL REPORT

By Mike Potchen

Coping with stress — a medical student's perspective

Some medical students will become impaired physicians. With medical school's emphasis on preventive medicine, students should be aware of the early manifestations of the problem and be cognizant of the means for early recognition and resources available to help those who are or about to become impaired.

Perhaps through a better understanding of the natural history of the problem and successful ways available to manage physician impairment, medical students can make an increased contribution for themselves, their colleagues and some of their physician mentors who they recognize as impaired. Often, an impaired health professional uses unacceptable means to manage his/her inability to cope with stress. These means may grow to encompass a variety of substance abuse.

Medical school is stressful. Most of us will develop strategies for dealing with stress while we are medical students.

Often this requires us to set realistic expectations so that the frustration of unmet expectations doesn't deal a stressful blow. It is critical that we, as students, realize that the inability to adequately deal with the stresses of our profession is a vulnerable area. It is also essential that we recognize that the problems of substance abuse are solvable, as this recognition is necessary for successful treatment.

An opportunity

As medical students become involved in the programs for the management of physician impairment, we can use this opportunity to develop skills important in our management of stress, and in the management of stress in our colleagues.

Often the key to developing coping skills is the ability to avoid isolation. Isolation increases the perception of stress by forcing people to deal with high pressures alone. In stressful situations, students should learn to seek early help and companionship from others.

While there has always been a need for medical students to develop acceptable and therapeutic coping skills, it may now be more important than ever. Students should be made aware of the availability of the professional help offered by the MSMS Impaired Physician's Program so that the system could be more widely understood and appreciated by the very people who may need it. In addition, there is need for students to get involved in the Impaired Physicians Program so that can grow to encompass students' problems and needs.☐

Mr. Potchen is a student in the College of Human Medicine, Michigan State University.

By Robert Niccolini, MD
and Jane Thomas, PhD

The extent of impairment at one Michigan medical school

The authors compiled the results of a five year retrospective study of medical students who were seen for phychiatric evaluation, treatment and/or disposition. The impaired students were considered to be representative of the general population of Wayne State University School of Medicine and by extrapolation, any large urban medical school population.

The male/female ratio of the impaired students was 79/21 as compared to a 83/17 ratio for the entire population. Of the impaired students only 16 percent were married as compared with 43 percent married in the total population. This was seen as an indication that the married students may have derived certain support from the marital relationship. Of the impaired students 34 percent were first seen in Year I, 28 percent in Year II, 43 percent in Year III, and only 4 percent in their last year. The age at initial psychiatric contact ranged from twenty to thirty years. In a group where the average freshman was 22-23 years and less than 30 percent of the students fell out of that range, 50 percent of the Year I impaired students were either older or younger at the time of evaluation. This may suggest an age-related support system for dealing with the stresses of medical school that proves less effective for the older or younger student.

The majority of the students (52 percent) were referred through the Office of Student Affairs. The remainder came to psychiatric intervention via administrative request (33 percent) and self-referral (15 percent). All but the administrative referrals were handled without involvement of any official medical school body.

Academic problems

The majority of the students that were referred were having academic failures of moderate to severe nature. Severe academic failure was defined as having failed an entire year. Failure of a major portion of an academic year (i.e. at least one of the seven units in Years I and II or one of the eight clinical rotations in Years III and IV) was defined as moderate academic failure. Thirty-three percent of the impaired students showed no serious academic problems as part of their symptomatology.

Behavior and attitudinal problems were reported in 42 percent of the students seen. The vast majority of these appeared in students who were first evaluated in Years III and IV. The majority of impaired students (58 percent) did not exhibit any serious personality problems as manifested in either attitude or behavior deemed inappropriate in the medical school or clinic setting. Several factors appeared possible. First it was considered that the lower percentage of reported behavioral or attitudinal difficulties might well be related to the fact that they are more difficult to document than academic failure. Secondly, the significantly higher percentage of behavior problems reported in Years III and IV are most likely related to the greater interpersonal skills required of the students in their clinical years.

Thirty-three percent of stu-

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Doctor Niccolini is chief of psychiatry, Hutzel Hospital, Detroit, and clinical associate professor, Wayne State University School of Medicine. Doctor Thomas is assistant to the Dean of Student Affairs, WSU School of Medicine.

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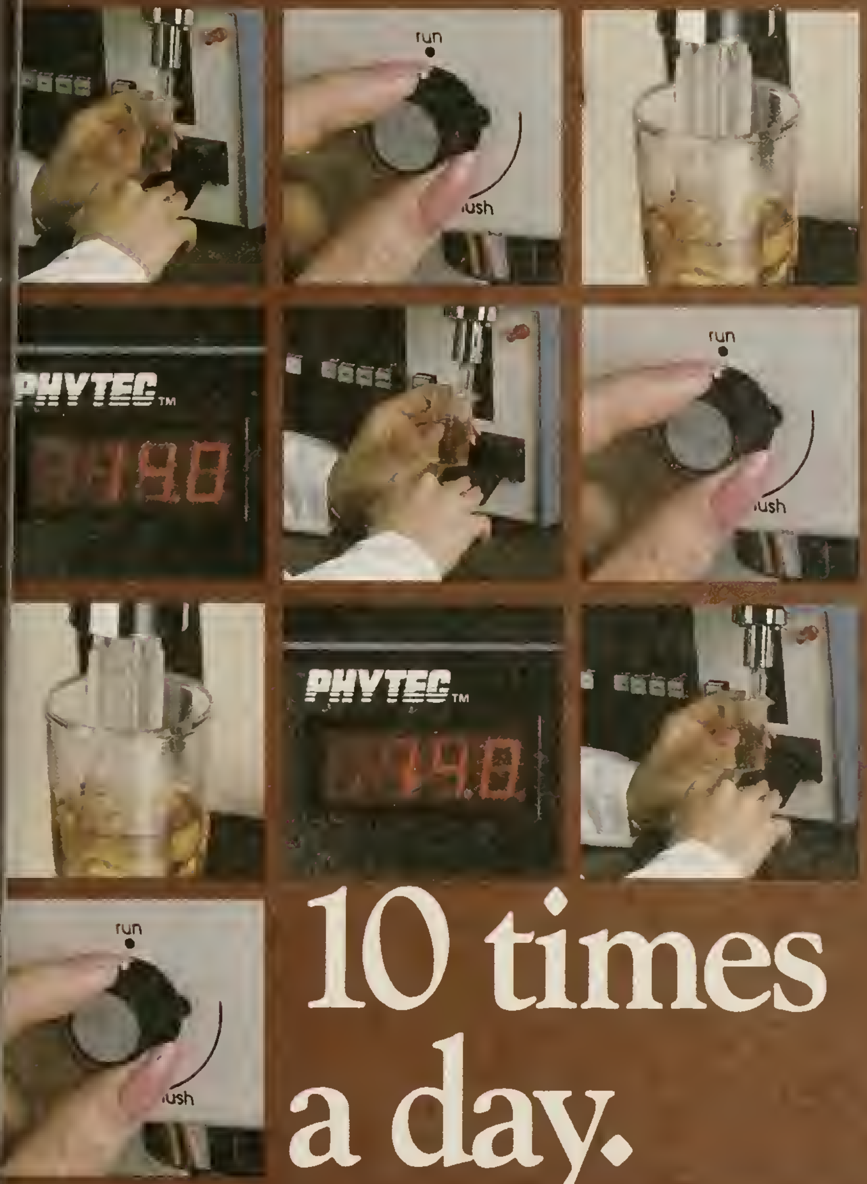

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dents reported alcohol or drugs as either a primary or a concomitant symptom in their history. In addition to alcohol the most commonly abused drugs were marijuana, amphetamines, cocaine and sedative-hypnotic drugs. There were no cases of hard-core (heroin) drug use and in no case was the alcohol or drug problem severe enough to warrant hospitalization. Physical symptoms including gastrointestinal disorders, weight loss, genito-urinary symptoms, frequent headaches, generalized malaise and weakness occurred in 33 percent of cases. In all cases physical examination and appropriate medical workup proved negative.

The following significant psychiatric and psychoilogic symptoms were reported by the impaired students either at the time of initial evaluation or during their treatment course. Depression was reported in 43 percent of cases. Anxiety was present in 33 percent. Family adjustment problems, which were primarily associated with parental rather than marital conflicts, were evident in 46 percent of students. Social and interactional maladjustments fell into three major types. Twenty-six percent of students exhibited a schizoid and withdrawn behavior pattern which significantly interfered with their ability to interact with other students, patients, and medical school and clinical staff. Fifteen percent showed immature and impulsive acting-out behavior and 12 percent evidenced behavior of a frankly anti-social nature. Ten percent of the students seen reported problems with obsessive-compulsive behavior pattern.

Of the 38 percent of impaired students exhibiting problems of a sexual nature, one third reported homosexual difficulties, and two thirds related sexual dysfunction or sexual identity problems of a heterosexual nature.

Primary diagnosis

A primary diagnosis was made in all cases. Twenty-three percent of the students were diagnosed as having adjustment or situational reactions. Twenty-three percent were considered to have personality disorders of various types and 43 percent were diagnosed as neurotic. The majority of the neurotic diagnoses were evenly distributed between anxiety reactions and depressive reactions, with a small number of obsessive-compulsive neuroses. Only 10 percent of the students were given psychotic diagnoses. All of these were considered to be major affective disorders of a manic-depressive type. The diagnosis of schizophrenis was not utilized.

At the time of the initial psychiatric intervention 45 percent of students were recommended for medical leave of absence from school. Forty-five percent of the impaired population were started in intensive, insight-oriented psychotherapy on a weekly basis. Thirty-five percent were recommended for supportive psychotherapy. Psychopharmacologic therapy (mainly anti-anxiety and antidepressant medication) was utilized in 16 percent of cases.

No further treatment was recommended for 10 percent of the students evaluated.

Of the total number of impaired students 60 percent were able to return to medical school and graduate. Twenty-five percent were eventually dismissed from medical school via the administrative route. After various periods of psychotherapy 15 percent of the students made the decision to voluntarily withdraw from medical school in favor of other careers.☐

By Sheri Greenhoe
Managing Editor

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fore prescribing, see complete prescribing information in SK&F CO. rature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

ntraindications: Concomitant use with other potassium-sparing agents ch as spironolactone or amiloride. Further use in anuria, progressive nal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum tassium. Hypersensitivity to either component or other sulfonamide- rived drugs.

arnings: **Do not use potassium supplements, dietary or otherwise, unless pokalemia develops or dietary intake of potassium is markedly impaired.** supplementary potassium is needed, potassium tablets should not be ed. Hyperkalemia can occur, and has been associated with cardiac irregu- rities. It is more likely in the severely ill, with urine volume less than e liter/day, the elderly and diabetics with suspected or confirmed renal sufficiency. Periodically, serum K^+ levels should be determined. If hyper- alemia develops, substitute a thiazide alone, restrict K^+ intake. **Asso- ated widened QRS complex or arrhythmia requires prompt additional erapy.** Thiazides cross the placental barrier and appear in cord blood. se in pregnancy requires weighing anticipated benefits against possible azards, including fetal or neonatal jaundice, thrombocytopenia, other dverse reactions seen in adults. Thiazides appear and triamterene may ppear in breast milk. If their use is essential, the patient should stop ursing. Adequate information on use in children is not available. Sensitivity actions may occur in patients with or without a history of allergy or ronchial asthma. Possible exacerbation or activation of systemic lupus rythematosus has been reported with thiazide diuretics.

recautions: The bioavailability of the hydrochlorothiazide component of yazide' is about 50% of the bioavailability of the single entity. Theoreti- ally, a patient transferred from the single entities of Dyrenium (triamterene, K&F CO.) and hydrochlorothiazide may show an increase in blood pressure r fluid retention. Similarly, it is also possible that the lesser hydro- hlorothiazide bioavailability could lead to increased serum potassium levels. owever, extensive clinical experience with 'Dyazide' suggests that these onditions have not been commonly observed in clinical practice. Do eriodic serum electrolyte determinations (particularly important in patients omiting excessively or receiving parenteral fluids, and during concurrent se with amphotericin B or corticosteroids or corticotropin [ACTH]). eriodic BUN and serum creatinine determinations should be made, specially in the elderly, diabetics or those with suspected or confirmed enal insufficiency. Cumulative effects of the drug may develop in patients ith impaired renal function. Thiazides should be used with caution in atients with impaired hepatic function. They can precipitate coma in atients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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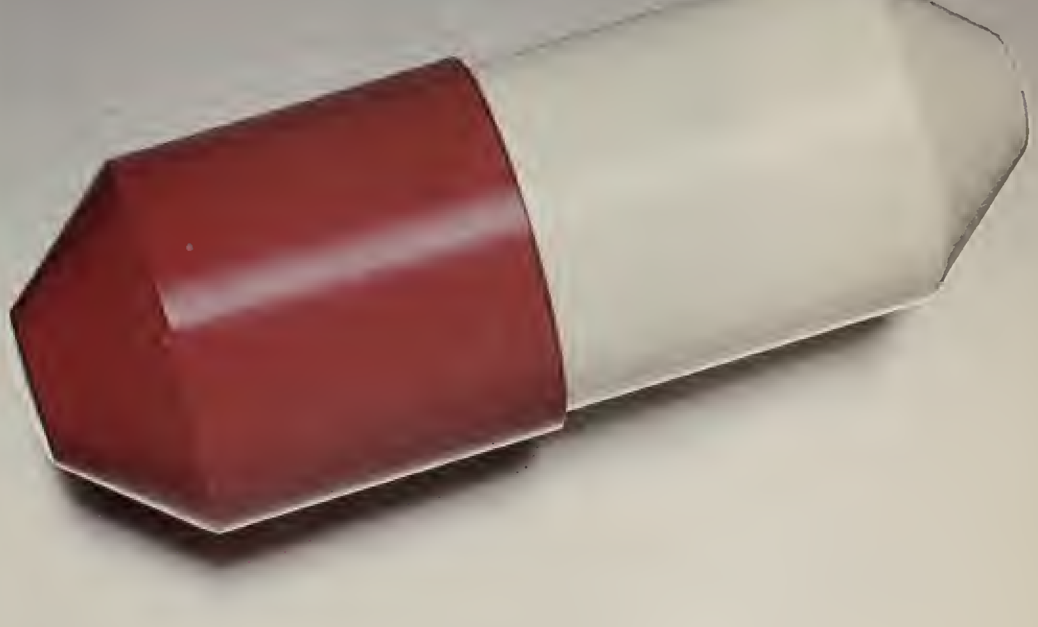

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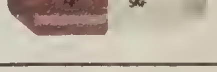

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Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

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42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page. 2/84

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

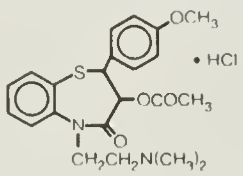
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM* (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure**. Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%) asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure syncope.
Nervous System:	Paresthesia, nervousness, somnolence tremor, insomnia, hallucinations, and amnesia
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting mild elevations of alkaline phosphatase, SGOT SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia, and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers**. (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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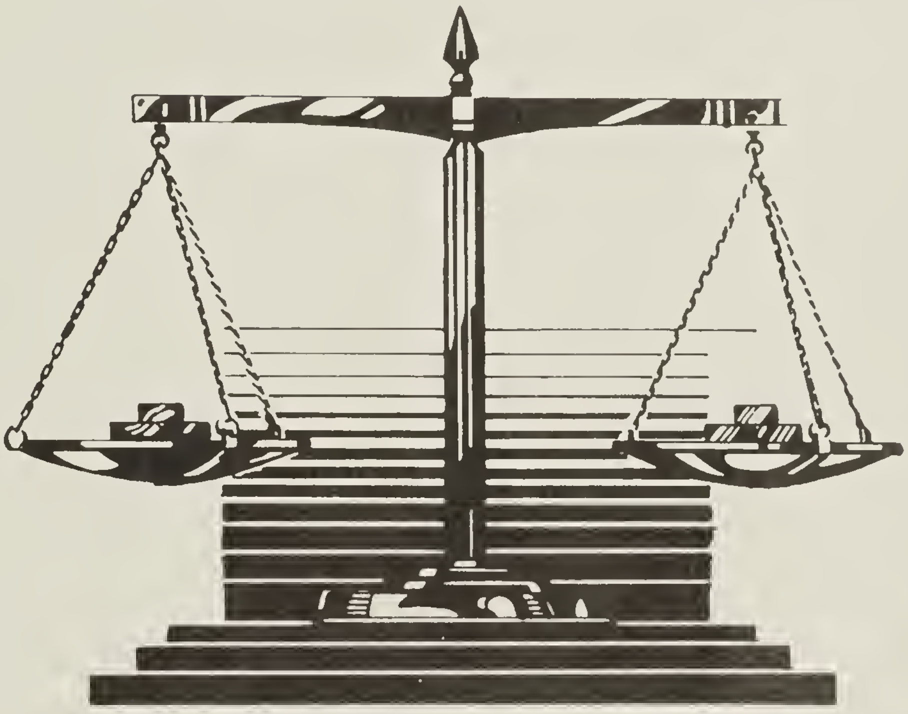
By John L. Shek, MD

An open letter to 'professors' who testify in liability suits



Under our MSMS president, Doctor Louis Zako, chairperson of the Professional Liability Task Force and Doctor Frederick Minkow, the problem of malpractice in medicine has never been placed in more acute focus. The February, 1985, issue of our official publication, *Michigan Medicine,* devoted 90 percent of its feature pages to this subject. One can get quite educated on medical liability by reading these articles in earnest. There is no shortage of thought and especially of emotion in wanting to alleviate the abuses.

However, the legal profession employs successfully the due process clause and equal protection under the Constitution to practically negate any attempt to change the contingent-fee system. New legislation against the status quo is characterized by the legal profession as being special treatment for a special interest and therefore unconstitutional. Only arbitration as an alternative discussed by Doctor Powsner has gained enough momentum—a glimmer of hope seems to be sustaining us. A solution is far from coming.

Good advice

It is good advice that we should combat our adversary with better defense records. Being more cautious, more vigilant, and more concerned might seem platitudinous but it helps. By not being overly-reliant on x-ray reports to eskew proper consultation with specialists, by recording the patient's understanding of his illness, by being wary of projecting an impersonal image, and by being patient with family members of the patient, we are helping our case.

However, there is another aspect we MDs should remember: "There is no malpractice unless another MD says so." An indiscriminate lawyer will use this as icon of truth to win his client and himself some money.

The usual group of MDs who testify for a fee about neonatology one day and vascular surgery the next has long caught the eyes of all who are concerned with such inequity. The issue of qualification of medical expert witness is even acknowledged by respectable plaintiff attorneys. However, the recent trend has been that some professors of medical colleges, after learning the handsome fee they could command are encouraged enough to become "hired-guns" for the plaintiff attorney.

They become dogmatic in propounding their own pet beliefs and in disparaging all other modalities of treatment as inferior, if not infidel. Their advocacy is such that their statistics cause the defendant MD's explanation to look pale beyond belief. Their didactic experience dominates a private practicing physician's lack

Continued on page 444

Doctor Shek is Assistant Clinical Professor, Surgery, College of Human Medicine at Michigan State University.

THIS SPACE CONTRIBUTED AS A PUBLIC SERVICE

How to live with someone who's living with cancer.

Learning to live with cancer is no easy task. Learning to live with someone else's cancer can be even more difficult.

Nobody knows better than we do how much help and understanding is needed. That's why our service and rehabilitation programs emphasize the whole family, not just the cancer patient.

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Among our regular services we provide information and guidance to patients and their families, transport patients to and from treatment, supply home care items and assist patients in their return to everyday life.

Life is what concerns us. The life of cancer patients. The lives of their families. So you can see we are even more than the research organization we are so well known to be.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®

TESTIFY/Continued

of experience in speech. Some defense attorneys, therefore, procure another "professor" to counter the hired gun.

The resulting scene is two professors fighting to convince the jury as to who is more right. The jury is asked to judge entirely from the education they received in the court room. Naturally, "truth" belongs to the professor who is more persuasive, more convincing, from a more recognized medical school, is better dressed, and even more handsome—in other words, the one who is in a more attractive package.

To expect a group of typical laypersons to learn enough medicine to decide which professor is correct is to expect the impossible. For a professor, no matter how noble, to address a court of law as if it were a lecture amphitheatre of a medical school is dangerous to say the least.

The purpose is not to gag or prohibit fellow MDs from exercising their constitutional right of free speech. Even if it is the testifying professor's desire to crucify the defendant, no law can prevent it. In a court of law, the expert witness is immune from legal action as it is but his or her opinion.

Time for action

It is time, in my opinion, that our prestigious medical schools, medical associations, medical societies, and specialty associations whose membership is coveted, take some self-regulatory action: to devise a code of ethics for all who belong. The ethics should stipulate that advocacy of one-sided pet beliefs in the diagnosis and treatment of certain diseases is encouraged in academic atmospheres, but not in a court of law. An MD who has earned the rank of professor should have a working knowledge of all aspects of the disease in question. With his mind subconsciously aware of the demand of ethics, it will chill his fervor in advocating his pet belief or desire to win the case for the hand that feeds. For, after all, we MDs are honorable, but sometimes we can be carried away.

A proposed solution

The Ethics Committee of the organization is not to arbitrate whether a member has breached the code, but to provide machinery for both the complainer and the complainee. Each of the two parties would choose a member to represent his point of view, and agree upon a third member to function as hearing officer. Primarily, the criteria should be whether the member has neglected to testify on all existing aspects and modalities involved in the discussed field of medicine. Their verdict would be final and subject to no appeal.

There would be no penalty meted out either by the Ethics Committee or this hearing committee of three. But, the outcome of the case should be recorded and published in the organization's official journal as to whether so-and-so was found to have breached the code. This decision would be published after the lawsuit was over to avoid any criticism by the legal profession that the organization is prejudicing a suit.

All members of the organization would be bound by this provision voluntarily. The chilling effect would be to hold members to the responsiblity of professorship and the integrity of the organization. The "penalty" would be the shame the member feels that his or her pride and sense of justice were adjudged by his peers, chosen by himself, as having been breached, and by publication made known to his peers statewide.

MDs as a group are dedicated to serve mankind and proud to be correct in our behavior. Such voluntary willingness to bond ourselves to this code of ethics would bring nothing but self-respect and respect from the citizenry. Making no demand on the legal profession, this endeavor should earn its respect and may even stimulate its members to become more ethical. ☐

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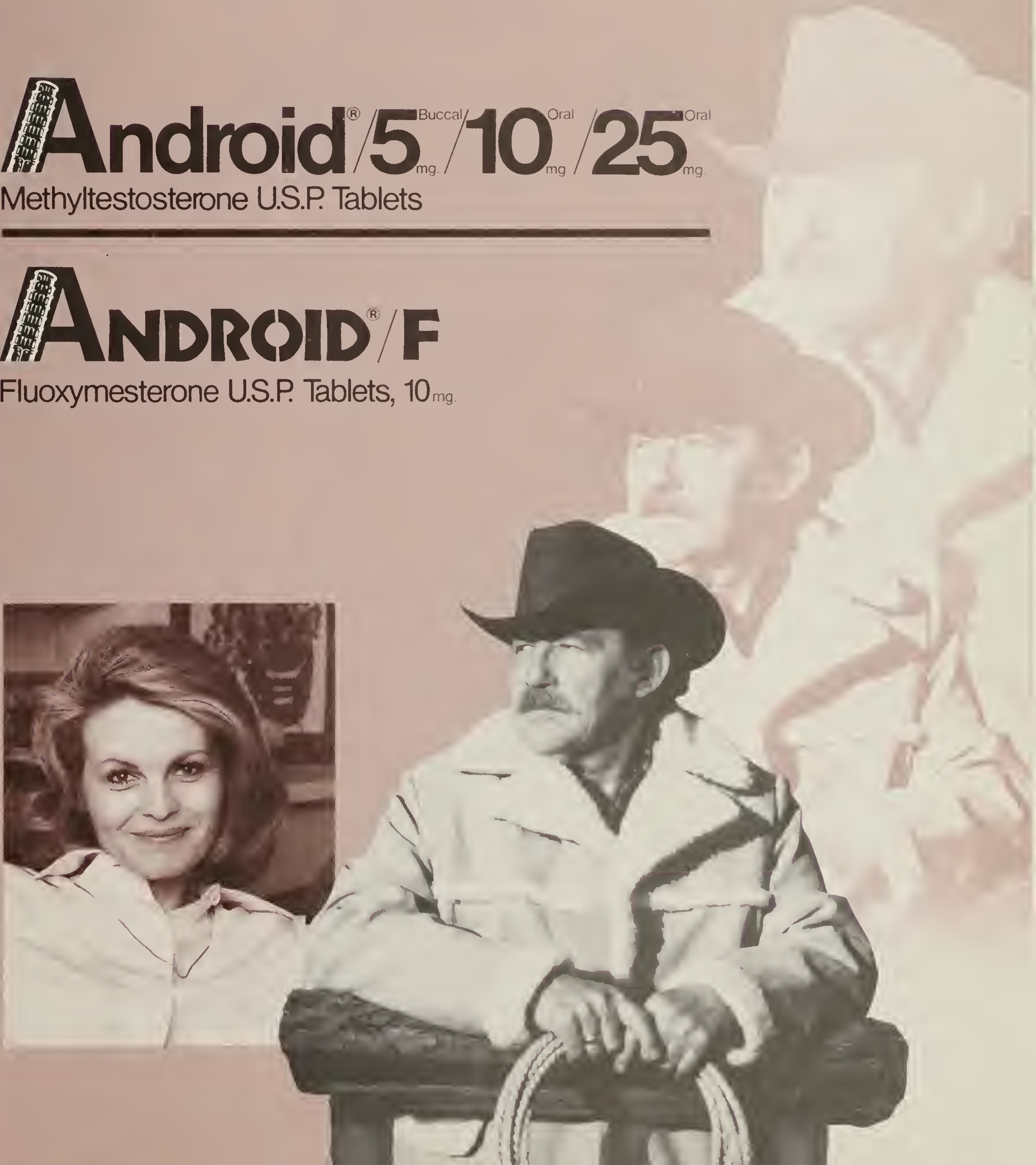


By Gerald H. Mandell, MD

MSMS officer testifies against chelation therapy

MSMS Speaker of the House of Delegates, Gerald Mandell, MD, made these remarks recently before the Michigan Board of Medicine:

As a pathologist I am aware of the ravages of degenerative vascular disease and specifically diseases of the coronary arteries. I have personally performed more than 800 adult autopsies and in the course of my teaching supervised some 2,000 adult autopsy cases. I, as most pathologists, have studied arteriosclerosis over my 29-year career in pathology. Thus, I qualify as an authority on the degenerative aspects of vascular disease.

I first became aware of the use of chelation therapy for arteriosclerosis around 1957 when an internist at Receiving Hospital in Detroit thought that the drug might have some potential use in reducing calcification within vessels. It is my understanding that he considered treating several patients, but if he did so his experiment did not last very long and, in fact, the physician left the Detroit area soon thereafter.

My next encounter with chelation was for its use in a 29-year-old woman who suffered from scleroderma in 1958. This unfortunate lady developed complications of skin ulceration and septic arthritis, which eventually killed her. She had the most severe osteoporosis that I have ever seen in any patient. Her bones were literally mush. I firmly believe that the severe osteoporosis that was present was a consequence of the EDTA therapy this patient received.

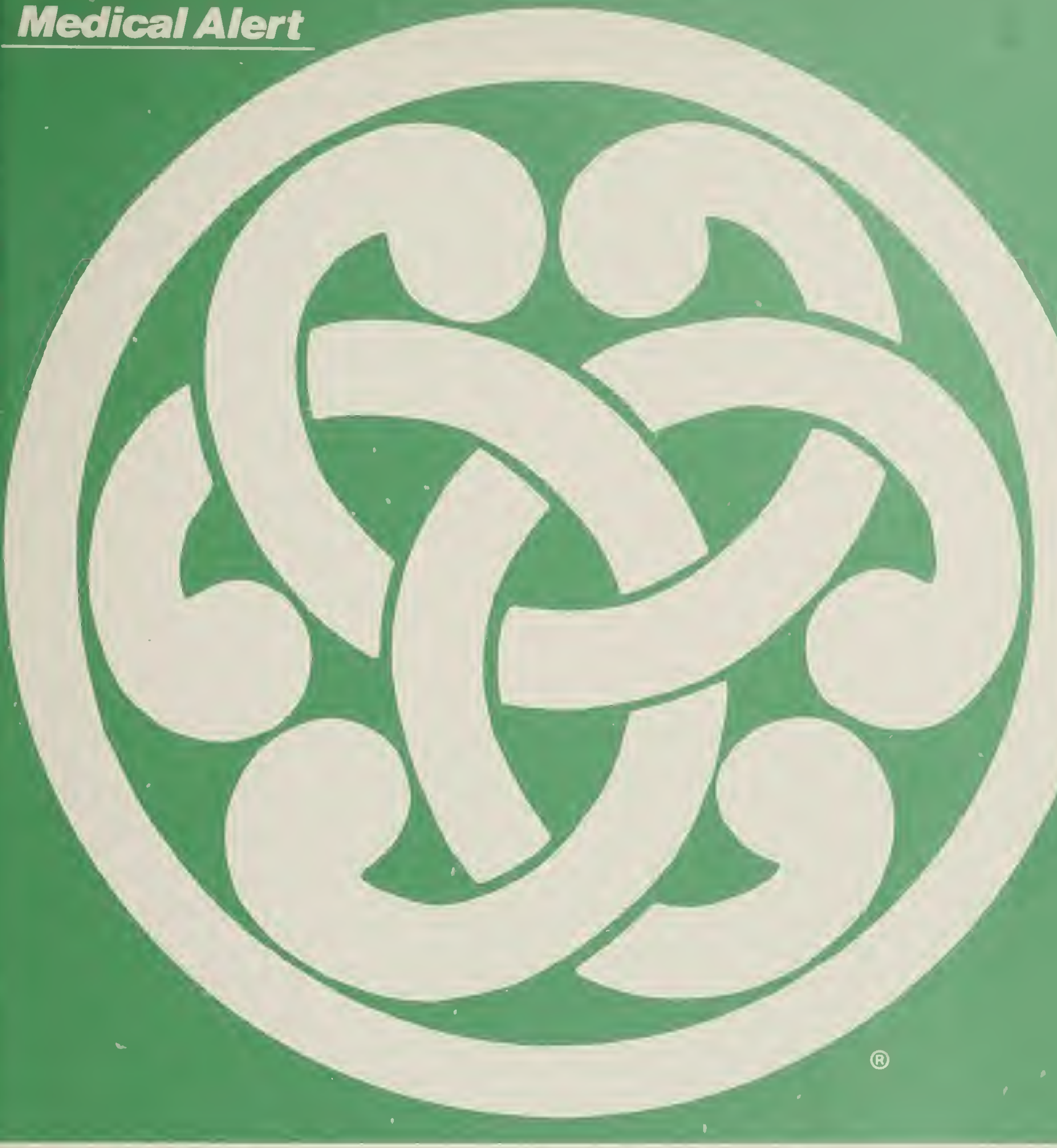
My next encounter with chelation was in hearing of the treatment offered for patients who had cardiovascular disease in the Detroit area and nationally as well. I was appalled to believe that any physician who understood pathology would think that there would be resolution of arteriosclerotic plaques and the attendant scarring by use of a chelating agent. I, therefore, began to read much of the literature available concerning chelation in an attempt to understand on what grounds such treatment was proposed. In no instance was I convinced that arguments about the removal of ionized calcium to remove atheromatous plaques or to alter sulfhydryl bonds in collagen were valid.

A major concern of organized medicine is that people who are led to receive chelation for arteriosclerosis are dissuaded from receiving appropriate care by physicians. We are beginning to hear occasional complaints from doctors that patients for whom they care have received chelation without benefit.

I stress that our concern in medicine is that the public is distracted from having appropriate care because of the persuasive advertisements for chelation therapy in the press and by publicity occasioned by talk show hosts. We in medicine are firmly convinced that the use of chelation constitutes a practice of medicine below an appropriate standard of care. There is no scientific proof that EDTA is effective in the treatment of cardiovascular disease. There has been no scientific study supporting its efficacy in this regard. Chelation therapy has never been approved for such use by the FDA. The American Medical Association and Michigan State Medical Society have both taken the position that those who advocate its use must be responsible for proving its efficacy. The issue here is: are patients led astray by false claims of benefit so that individuals suffer severe morbidity and fatality as a result?

I, therefore, representing the Michigan State Medical Society and what I believe to be the position of reputable physicians in this state, ask the Board of Medicine to declare that the use of chelation therapy for arteriosclerotic cardiovasular disease is below an acceptable standard of practice of medicine.☐

Medical Alert



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Know Your CMR

By Judy Marr, Editor

1985 Scientific Meeting chairman excited about new courses

Serving his first year as MSMS Annual Scientific Meeting chairman, C. Edward Cotton, MD, Marcellus, is shooting for "the largest number of doctors attending the meeting we've had in the past 10 years."

The Annual Scientific Meeting happens to be 10 years old this year, so it follows that Doctor Cotton hopes to draw the largest crowd ever.

"I'm shooting to beat all the previous chairmen," says Doctor Cotton. "Of course, this is a friendly competition."

Doctor Cotton, a family physician, succeeds David R. Rovner, MD, East Lansing endocrinologist, as Annual Scientific Meeting chairman. Previous chairmen are Carl F. Hammerstrom, MD, Marquette internist; Samuel M. McMahon, MD, Lansing pulmonologist, and Robert F. Wilson, MD, Detroit thoracic surgeon.

Doctor Cotton, a veteran of the Annual Scientific Meeting Planning Committee, says he has been most impressed with the number of fine programs presented to the committee for its selection this year.

"They have allowed us to choose the cream of the crop," he says.

Doctor Cotton took the job of Annual Scientific Meeting chairman, he says, because he saw it as a personal challenge—"to see if I could continue the excellence."

He believes that because of his activities with the Michigan Academy of Family Physicians (he is immediate past president) he has been able to put together a program with strong appeal to the primary care physician.

"This is in addition to our usual sophisticated presentations to specialists," he emphasizes.

Popular topics

The committee, under his leadership, has worked to meet some of the needs expressed by physicians surveyed recently by the American Academy of Family Physicians.

"Physicians surveyed said they were more interested in studying a particular disease in-depth than attending a potpourri of courses," he reports.

Thus this year's "alpha-omega" courses, he explains, describe the progress of a disease entity as a person ages. The committee has planned two sets of three courses each on the subjects of diabetes and pulmonary disease.

The series courses are staggered throughout the three-day Annual Scientific Meeting so that a physician attending the entire meeting may study the complete disease process.

Physicians who attend all three days of the Annual Scientific Meeting also will get a financial break. They will be charged *last* year's prices.

"The committee has worked especially hard this year," says Doctor Cotton. "We have put together a program which will provide in-depth study, describe the newest and latest developments in technology and will give us the information we need to improve the care of our patients at home."

"I look forward to seeing my colleagues in Dearborn."☐

Interested physicians should begin planning now to attend the 1985 MSMS Annual Scientific Meeting November 12-14 at the Hyatt Regency Dearborn.

The physician attending the entire three-day meeting may earn a maximum of 18 Category I CME credits. Each of the 55 half-day courses attended earns the physician three credits.

Fees for MSMS members this year are $7 per credit hour, or $21 per course.

C. Edward Cotton, MD, Marcellus family physician, is meeting chairman this year. He heads a planning committee consisting of Frederick W. Bryant, MD, Royal Oak; Dorothy Kahkonen, MD, Detroit; Kenneth L. Krabbenhoft, MD, Detroit; Nicholas J. Lekas, MD, Dearborn; Samuel M. McMahon, MD, Lansing; Richard M. Nowak, MD, Detroit, and Joan C. Stryker, MD, Detroit.

Complete Annual Scientific Meeting details, including registration forms, will appear in coming issues of *Michigan Medicine* and *Medigram*. In the meantime, information is available from Sherry Fent at MSMS headquarters (517)337-1351.☐

1985 MSMS ANNUAL
SCIENTIFIC MEETING
November 12, 13 & 14
Hyatt Regency Dearborn

Pediatric health guidelines

The American Academy of Pediatrics' (AAP) "Guidelines for Health Supervision" will give pediatricians a handy reference not only for physical checkups from infancy to the twentieth year, but for emotional checkups as well. It is accompanied by cue cards which highlight information to be asked at each visit.

The manual and cue cards, written by the AAP's Committee on the Psychosocial Aspects of Child and Family Health, are a response to the changes in the pediatric field that have developed over the last decade. More and more pediatricians—about 25 percent—are seeing adolescents in their practices.

"Guidelines for Health Supervision" can be purchased for $25 through the Academy's Department of Publications, P.O. Box 927, Elk Grove Village, IL 60007.

Publications on medical care costs

The AMA has published two new booklets directed toward the general public. Both encourage the cost-effective utilization of health services through an increased knowledge of the health care system.

What You Can Do About Health Care Costs discribes some of the reasons for rising health care costs, some of the things physicians are doing to make medical care more economical, and some of the things patients can do to reduce the cost of their own care. The booklet stresses the importance of such things as maintaining personal medical histories, using the physician's time more effectively, considering all medical options, and becoming more familiar with health insurance benefits. Most importantly, the booklet urges the patient to work in partnership with his/her personal physician to reduce the overall cost of medical care.

Let's Talk About Health Insurance discusses the types of health insurance coverage and health care financing plans, new alternatives to traditional health care settings, initiatives to hold down health care costs, contract provisions, how to choose an insuring organization, and a glossary of health insurance terms.

Both booklets are packaged in units of 10 copies (single copies are not available). Prices include postage and handling. AMA members receive a 10 percent discount. For more information, contact the AMA Book and Pamphlet Fulfillment staff at (312)280-7168.

Reye's Syndrome winter summary

During the period from October 1, 1984 to April 30, 1985 thirteen cases of Reye's syndrome were reported to the Michigan Department of Public Health. Three of these cases died. During this same period in 1983-1984 there were 20 cases with three deaths, in 1982-1983 there were 11 cases with one death, in 1981-1982 there were 21 cases with seven deaths, and in 1980-81 there were 18 cases and no deaths.

The age of cases ranged from two months to 16 years. The mean age of cases was 5.5 years, the median age was 2.5 years. There were seven females and six males. The cases were from 11 different counties. Kalamazoo and Wayne were the only counties which reported more than one case.

During 1984-85 there were only two reported school closings due to influenza-like illness. Reported influenza-like illness rose above 8,000 cases on the week ending December 21 and then again for most of the period from January 25th to April 12th. Although this pattern was similar to the reports of influenza-like illness in 1983-84, there were four weeks last year when reports ranged from 14,000 to 21,000 cases, whereas the highest number of reports for a week in 1984-85 was under 13,000 cases. No evidence for the presence of influenza B was seen in Michigan and only Influenza A H3N2 was identified by isolation or serology.

Michigan reported the most cases in the Great Lakes region with thirteen in the period October 1, 1984 to April 30, 1985. Ohio and Wisconsin reported six cases in this period for the second highest count for a Great Lakes state.

Laser phototherapy

There are approximately 30,000 new cases of bladder cancer a year. But no longer does the diagnosis of bladder cancer automatically mean the imminent removal of the bladder and the lifelong wearing of a plastic bag to which urine is diverted.

Henry Ford Hospital (HFH) now is among the few medical centers in the US in which a multi-specialty team uses laser and electronics to pinpoint and then treat cancer within a cavity, in this case superficial cancer in the bladder. Staff physicians say the closest other hospital using the technique is the Mayo Clinic in Rochester, Minnesota.

The first step is the insertion of the diagnostic probe through the urethra. The procedure resembles the endoscopic exam performed in any urologist's office.

To detect the precise location of the cancerous cells within the expanded bladder, a unique device called a "chopper" is used. It is a portable box of solid-state sensors and monitors. The "chopper" allows physicians to detect the cancerous regions, which, when treated with the harmless drug hematopopophyria derivative (HPD), fluoresce when illuminated by the laser. The "chopper" uses digital and dial indicators as well as an audible signal which intensifies as the laser probe sweeps over the cancerous region of the bladder.

Once the fiber-optic bundle which carries the laser light is sterilized, a light tip is attached. The bundle is inserted via the endoscope tube and a carefully-timed dose of laser therapy is begun. The intensive light energy of the laser destroys the cancer-us cells which have been sensitized to light by the HPD drug. 'he only known side effect of IPD is sensitivity to sunburn for vo weeks after treatment. Pa- ents are advised to wear a unscreen outdoors.)

Following the treatment, during vhich the anesthetized patient imply lies on the OR table and physician periodically checks he laser's position, a section of he treated area is biopsied to heck for success of the proce- lure.

While the procedure is still :onsidered experimental, it is approved by the Food and Drug Administration and is being done by about 10 centers in the US.

Patients are checked every three months the first year following treatment, twice the second year and annually thereafter. So far, all patients having undergone the procedure at HFH have shown no recurring bladder cancer at their one-year follow-up. Cost of the procedure is the same as that of a cystopic procedure and it may someday be performed on an outpatient basis.

Drugs and the kidneys

The National Kidney Foundation of Michigan announces the availability of a new publication entitled *Drugs and the Kidneys*.

This new brochure, written by Stephen Midgal, MD, co-director of Nephrology at Hutzel Hospital in Detroit and a member of the Kidney Foundation Scientific Advisory Board, briefly outlines some of the side effects of over-the-counter medications, alcohol and prescription drugs on the kidneys. Of particular interest is the effect these drugs could have on persons already suffering from kidney disease.

To receive a free copy of this brochure call the Kidney Foundation toll-free at 1-800-482-1455.

Health services Masters program

The University of Michigan's non-residential Masters degree program in health services administration is now recruiting for its ninth class, scheduled to begin in April, 1986.

The program makes it possible for students to retain their employment while traveling to Ann Arbor once each month for an intensive four-day weekend of classwork.

The program curriculum covers: the operation of the health care system; its organization, financing and performance; administrative and planning techniques and approaches; the application of social science analysis to the health care system; and the application of a range of analytic techniques appropriate to the identification and solution of management problems in health care delivery.

The two-year, 48-credit masters program is now accepting applications for April, 1986. Write to: David Perlman, MPH, The OJ/OC Program, Department of Medical Care Organization, School of Public Health, University of Michigan, Ann Arbor 48109-2029.

Study shows no PBB effects

Preliminary results of a University of Michigan study of the effects of PBB on offspring show that a group of children whose mothers were exposed to PBB appears to be normal in five health measurements. Jill G. Joseph, MPH, PhD, assistant professor of epidemiology in the University of Michigan School of Public Health, led a research team that surveyed more than 1,000 mothers exposed to PBB who have young children. The mothers submitted breast-milk specimens

Continued on page 452

Burns Clinic Medical Center P.C.

13th Annual Medical Meeting
October 5 and 6, 1985

The Geriatric Challenge – The Medical Response

Guest lecturers will include:

Jeffrey B. Halter, M.D.
Professor of Internal Medicine
Chief of Geriatrics
University of Michigan Medical School

Carol A. Kauffman, M.D.
Professor of Internal Medicine
University of Michigan Medical School
Chief of Infectious Diseases
V.A. Medical Center, Ann Arbor

Howard Duncan, M.D.
Division Head – Rheumatology
Henry Ford Hospital

E. James Funk, Jr., M.D.
Peachtree Orthopedic Clinic
Atlanta, Georgia

Additional lectures and diagnostic workshops will be presented by the Burns Clinic Medical Staff

CME Category 1 Credits: 12
Registration Fee: $120.00
Saturday or Sunday only: $60.00
Holiday Inn and Burns Clinic
Medical Center, P.C.
560 W. Mitchell
Petoskey, MI 49770

For Further Information:
H. Michael Topley, M.D.
Chairman, Education Committee
616-348-4500

for PBB analysis at the time they were nursing six years ago.

In her preliminary report of the survey, commissioned by the Michigan Toxic Substance Control Commission, Joseph said, "Our initial analysis shows that PBB was not associated with any of the adverse health effects studied to date in this group of exposed children."

Epidemiology training program

The US Public Health Service (USPHS) invites applications for a planned extension of a training program in medical epidemiology. Up to 11 persons per year, who already have an MD, a Doctorate in an allied health profession, or PhD in a biomedical or behavioral science, Biochemistry, Psychology, or equivalent, may be accepted as service fellows of the USPHS (a non-tenured, junior professional classification under civil service) for up to a three-year period of duty. Applications received by September 10, 1985 may be considered for service to begin between July 1 and September 1, 1986.

Basic requirement for application to the program are:

1. MD, Doctorate in an allied health profession, or PhD in a biomedical or behavioral science, or equivalent, *and* one year of Post-Doctoral training or experience (by July 1, 1986); 2. US citizenship at time of application; 3. Acceptability to an accredited university offering an MPH or equivalent, or more advanced public health degree.

To obtain further program details and application forms, send a postcard only, with your *printed* name and home mailing address to: Robert S. Gordon, Jr., MD, MHS, Chairman, Steering Committee, NIH, Building 1, Room 238 Bethesda, Maryland 20205.

The children in the sample were exposed to levels of PBB that ranged from not detectable to moderate, while the average leve for the group was low, typical of that for the state population, she said.

New continuing care community

Additional health care for metro-Detroit's growing eastside aging population will result with the creation of Saint John Continuing Care Community. The Michigan Department of Public Health opened the way by approving the project in concept.

St. John Hospital and St. Clair Health Corporation purchased 12 acres on East Warren the former Austin Catholic High School and Wayne Community College Property. Buildings will be renovated and a multi-purposed group of living units for senior citizens and the ill will be built. Planned are a skill nursing facility, supervised residential care facility, senior citizen apartments and a hospice.☐

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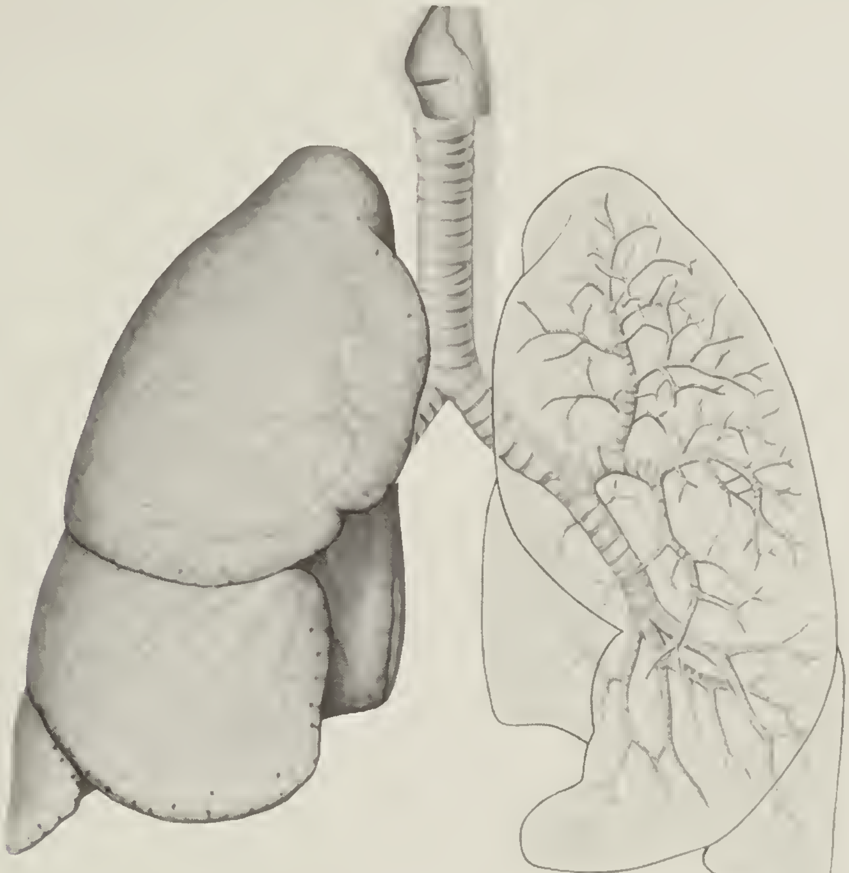

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cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information

Indications and Usage Ceclor* (cefaclor Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae* and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases management should include sigmoidoscopy appropriate bacteriologic studies and fluid electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents, e g pressor amines antihistamines or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip USP Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly) There are however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[0617B2R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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— Since 1968 —

By Cathie L. Marti

Reach out to colleagues facing lawsuits

When physicians are faced with a malpractice suit, or even the threat of one, they and their families find themselves trying to deal with yet one more emotional stress in their already demanding lives. Malpractice insurance rates increased in Michigan this summer. Doctors who spent years of study and training are beginning to limit procedures in their practice in order to reduce the cost of insurance and the risk of suit. Doctors and their families are leaving well established practices and moving to other states where insurance premiums are less.

These are sad times and solemn words. In the words of our AMA Auxiliary President-elect Mary Kay McFee, "The future of medicine is bright with promise and frought with problems." But hope is in sight. Currently, the MSMS Task Force on Professional Liability, chaired by Louis Zako, MD, immediate past president of MSMS, is working to develop and draft legislation toward alleviation of the professional liability crisis in Michigan. We auxilians can help MSMS ... and we will.

In the meantime, what about the physician and his or her family during or after a malpractice suit? How do you approach them? What do you say? Should we pretend it hasn't happened? Will we be more comfortable not talking about it? Doctor Kubler-Ross— world famous psychiatrist specializing in death and dying — tells us to reach out and offer a grieving family sympathy and support. I am sure she would agree that we must take the same steps with the physician family trying to cope with the nightmare of litigation.

As Doctor James Sammons, MD, AMA president, advised during a recent speech in Chicago, "If we really want to protect medicine and the medical family, we must stay unified."☐

Mrs. Martin, Traverse City, is MSMS/A president.

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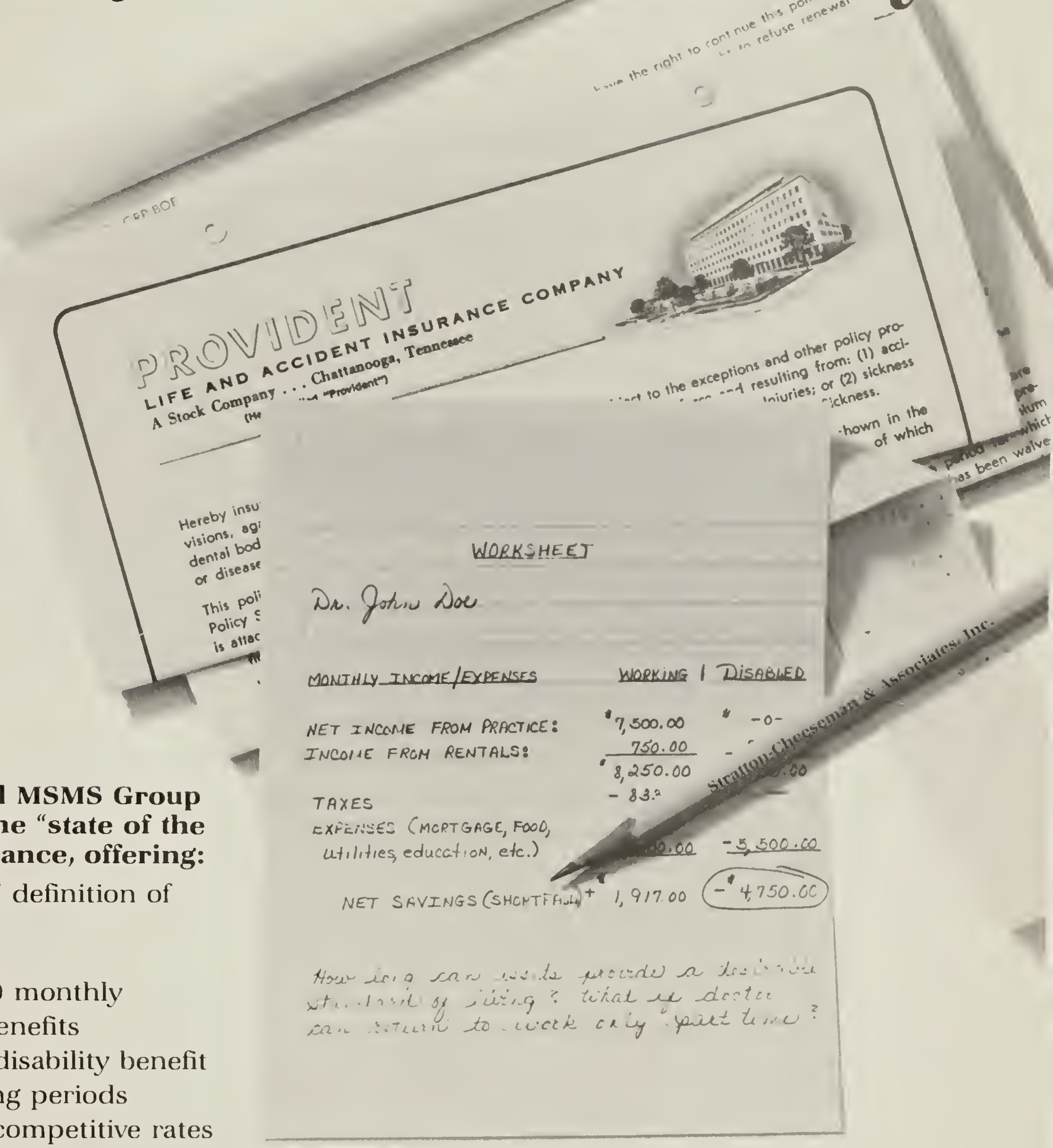

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By Mark I. Evans, MD

Chorionic villus sampling detects more than 100 fetal abnormalities

Over the past fifteen years, genetic amniocentesis performed in the mid-trimester of pregnancy has assumed a very important place in modern obstetrics. Through its use, the detection of cytogenetic abnormalities as well as over 100 biochemical abnormalities, have been achieved. The procedure is reliable, and with the concurrent use of realtime ultrasound to guide needle placement, amniocentesis has become increasingly safer over the years. Failure to offer the procedure to patients in appropriate risk categories has been clearly determined to be negligence by the courts.

Unfortunately, amniocentesis has several drawbacks. Principally, the procedure can not be performed safely until well into the mid-trimester of pregnancy (16-18 weeks with safety increasing with gestational age). By the time that results are available (two weeks after the specimen is obtained in our laboratory, up to four weeks in many) the mother has already experienced quickening and has made the important psychological transition from the state of "being pregnant" to "going to have a baby." Termination of a wanted pregnancy for an abnormality often cannot be accomplished much before 20 weeks of gestation and can be emotionally traumatic as it involves a labor and delivery type of experience.

Sampling of first trimester placental tissue by a transcervical route was first used successfully by the Chinese in the early 1970s for the purpose of fetal sexing. Soviet investigators later in the 1970s also were able to achieve similar results and began using ultrasound guidance to increase the safety and efficiency of the procedure. In the early 1980s, Italian investigators further refined the laboratory procedure and achieved full cytogenetic karyotypes. Over the past few years, several European and American groups have refined the technology and allowed chorionic villus sampling (CVS) to become a clinical option for selected patients. Research in our laboratory has led to improvement in cytogenetic quality and has established baselines necessary for the biochemical determinations necessary prior to attempted diagnosis of several disorders.

The advantages of CVS are that

Continued on page 458

Doctor Evans is director, Division of Reproductive Genetics, Division of Obstetrics and Gynecology, Wayne State University/Hutzel Hospital, Detroit.

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Danny Thomas, Founder
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SAMPLING/Continued

the test can be done at 9-10 weeks of gestation, results are available within 1-2 days and the couple can have privacy in their quest for information. The disadvantages of CVS are that even in the most experienced hands the risk of a spontaneous abortion following the procedure is higher than that associated with amniocentesis and is probably in the one or two percent range.

The Federal Food and Drug Administration is allowing only a few groups to perform the test. Hutzel Hospital has the only FDA approved program in the state of Michigan.

Patients who are appropriate candidates for prenatal diagnosis, either for cytogenetic or biochemical indications, may request the chorionic villus sampling procedure. The procedure is optimally performed between 9-10 weeks from the last menstrual period.

Patients who desire the service are seen in consultation as early in pregnancy as possible and ar given an ultrasound to confirm gestational age. At the consultation, the speific indications for prenatal diagnosis are reviewed and the patient is given a detaile explanation of the pros and con of CVS versus amniocentesis.

Following that is an informed consent process necessary to satisfy FDA requirements, including a statement of the FDA's position that the procedure is experimental.

For patients wishing to proceed, appointments for the ultrasound (a sector scan is usually needed) and the CVS procedure are scheduled. Results are telephoned to both the physician and patient approximately two days after the procedure. Since alphafetoprotein testing cannot be done on chorionic villi, maternal serum AFP sample is requested at about 16-18 weeks gestation.☐

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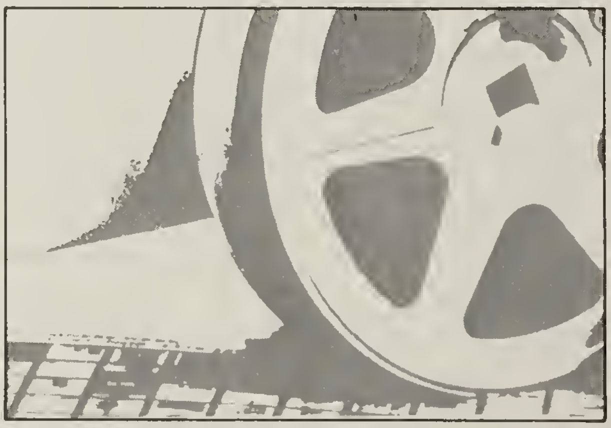

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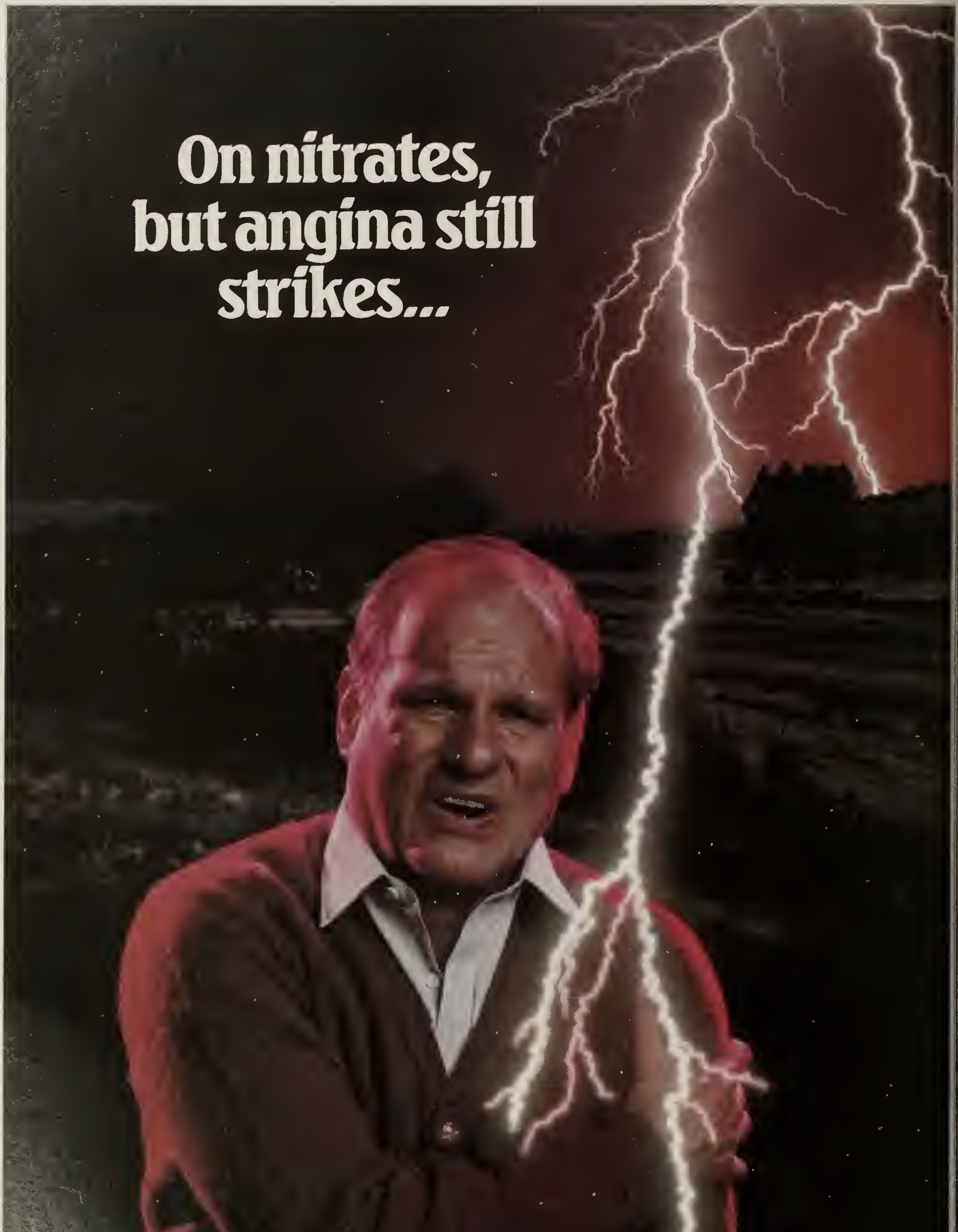
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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

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Please see brief summary on following page.

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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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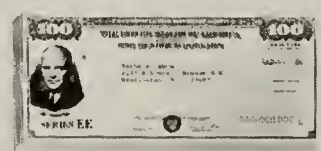

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PHYSICIANS IN THE NEWS

By Sheri W. Greenhoe
Managing Editor

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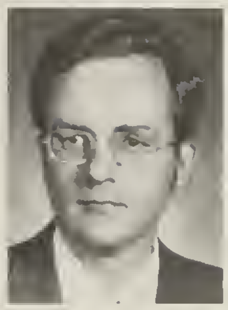

Dubin

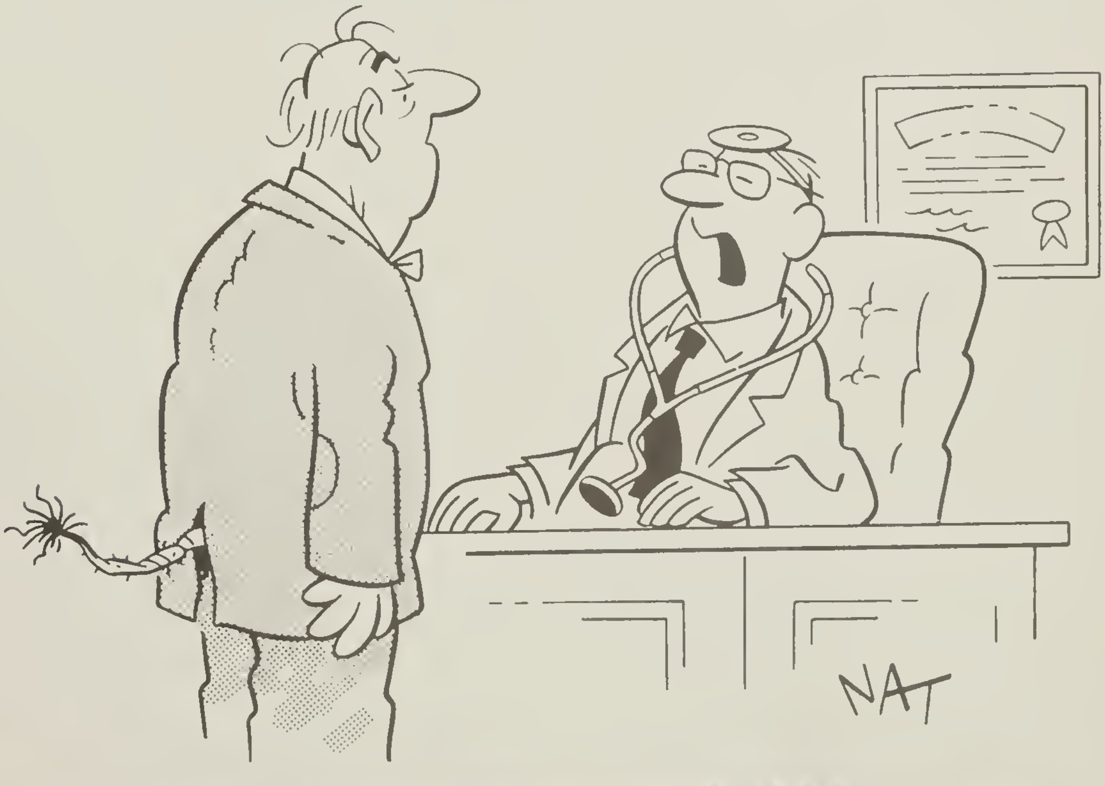
Gresch

Margolis

Meisel

Mucasey

hilip M. Margolis, MD, Ann rbor, professor of psychiatry and ommunity mental health at the niversity of Michigan, has been lected to the American Psychitric Association Board of Trusees. He will serve as a Trustee-atarge. ... **James H. Thrall, MD,** etroit, chairman of Diagnostic adiology at Detroit's Henry Ford ospital has co-authored a new ook entitled "Diagnostic Interentions in Nuclear Medicine." .. **Wolf W. Zuelzer, MD,** is the 1985 recipient of the John Howand Award of the American Pediatric Society, for his contribution to pediatrics. Doctor Zuelzer has maintained a dedicated 35-year association with Children's Hospital of Michigan. ... **Jeanne M. Lusher, MD,** director of the Division of Hematology-Oncology, Children's Hospital of Michigan, chaired the AIDS Interdisciplinary Workshop in Denver recently. ... **Clifford J. Bedore, MD,** Greenville, was honored for "outstanding volunteer contributions to his peers and community" at a meeting of the Area Agency on Aging of Western Michigan. He was co-winner of the nine county agency's Eleanor Hargrove Award. ... **James Chamness, MD,** Holland pediatrician, was honored with the Ottawa County Bar Association Liberty Bell award. This is the association's highest honor to a community member. Doctor Chamness was chosen for his efforts against child abuse and neglect. ... **Edward H. Meisel, MD,** Midland, has been honored by Midland Civitan Club as Citizen of the Year. Doctor Meisel currently is president of the Midland County Medical Society. ... **Elizabeth E. Gresch, MD,** Midland, has been appointed Speaker of the House of Delegates of the American Occupational Medical Association. ... **Martin L. Welsman, MD,** Southfield, participated in a two-month medical care mission with Project Hope on the island of Grenada in the Caribbean. ... **John Mucasey, MD,** Detroit, was awarded membership in the American College of Physician Executives during its 1985 National Conference on Health Care Leadership and Management. ... **Robert Fezzey, MD, Andrew Hauser, MD,** and **George Ritter, MD,** all of Oakland County, are among those named to the Board of Trustees of the American Heart Association of Michigan. ... **Howard V. Dubin, MD,** Ann Arbor, has been elected president of the Michigan Dermatological Society for 1985-86.☐



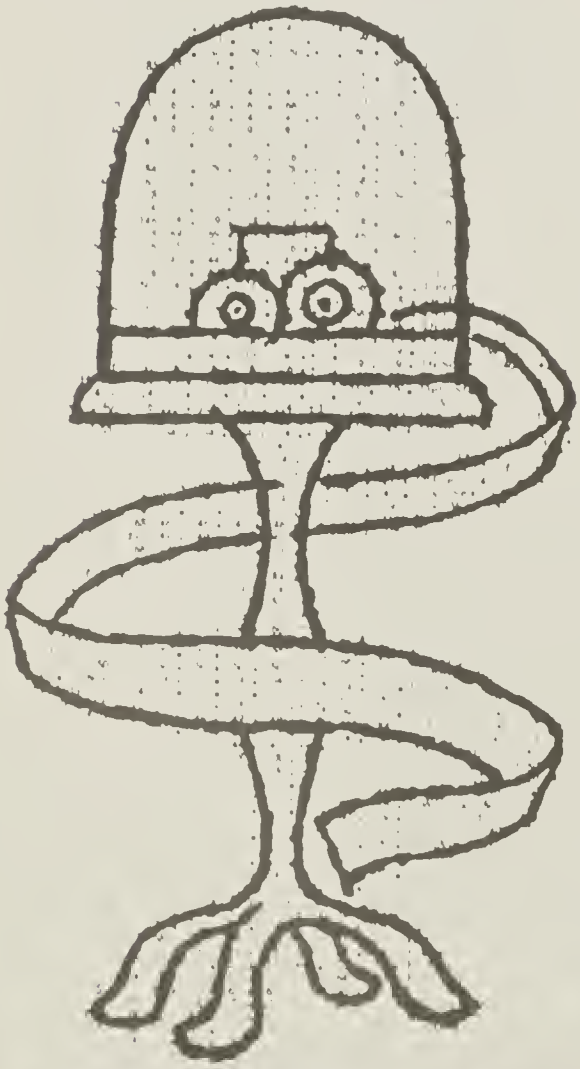
"That is correct, sir. I did mention possible side effects."

By Katharine S. Brown

Which type of investor are you?

Every time you buy or sell a stock, you are in danger of making a mistake. Most investors are well aware of this. For that reason, some investors are reluctant to do anything at all. Regardless of the changes taking place on the investment scene, they choose to stand pat. Perhaps they are convinced that they can't make a mistake if they stubbornly stick with the same portfolio.

Ms. Brown is an investment advisor with Prescott, Ball & Turben, Inc., East Lansing.



This refusal to make a change is, in itself, faulty strategy and is not a recommended course of action. As you may have found out, the fortunes of stocks don't stand pat. They change every day:

- Stock prices change
- Dividends are raised and lowered
- Officers get hired and fired
- New products succeed or fail
- Interest rates go up and down
- The dollar gets stronger or weaker
- Foreign competition may threaten domestic markets
- Inflation hurts some companies, but helps others
- Energy prices fluctuate
- Industries are deregulated, or regulations are imposed
- Mergers and takeovers benefit those who have invested wisely
- Changes in business conditions exert a major impact on most stocks

You don't have to stretch your imagination very much to realize that the above list of changes is almost infinite. That's why you can't afford to ignore your holdings. Even if you own the most prestigious blue chips, time can deal you some devastating blows.

Active Investing

The inactive investor—the one who believes that patience and long-term investing will solve all problems, is one type of investor. Now, let's focus on the person who is convinced of exactly the opposite. This investor is continually making switches, in hopes that he can achieve superior results by selling his winners and switching into something else. This active investor often buys low-priced stocks, rides them up for a few points and quickly unloads, fearing the stock will soon go back down again. In other words, he has no faith that the stock might double or triple over the next three or four years. He is convinced that "you can't lose money by taking a profit."

Following this ancient Wall Street maxim essentially guarantees you *will* lose money or, at least, your total portfolio results will be less than exciting.

The reason you should have more patience is *because* of your losers. Since there is no way to avoid losers entirely, it stands to reason that you need some big winners to make up for them. Thus, if you sell too soon—let's say after a stock has risen only 15-20 percent — you deprive yourself of these big gains that will give your portfolio some glamour.

What about the losers?

There's another Wall Street saying that advises investors to "sell your losers and let your profits run." Although I am no great believer in Wall Street maxims, I

Continued on page 466

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must confess that this one makes a lot of sense. The problem with this piece of advice is that it's not easy to recognize a loser. Some people use stop loss orders. If they buy a stock for $40, for instance, they seek to protect themselves by putting in a stop loss order at $36, thus keeping the loss to 10 percent. Of course, a stop loss order doesn't always work that precisely. It merely triggers a sell "at the market," once the stock falls to the $36 level. Your actual execution could be $35 ½, or lower, depending on the factor that produced the weakness.

Even if the stop loss order guaranteed the sale of your stock at $36, that wouldn't mean you have necessarily done the right thing. All stocks go down once in a while, even when the outlook is still promising. A 10 percent dip could be merely a minor ripple that is meaningless in a long-term uptrend.

Signs of deterioration

In order to recognize signs of deterioration, these are some of the questions an investor must ask: 1) Are order rates slowing?; 2) Are backlog cancellations increasing?; 3) Is the company's market position deteriorating?; 4) Are other companies introducing more innovative products?; 5) Is the company having production or delivery problems?; 6) Is management or the financial community continually reducing expectations for revenues and earnings?; 7) Is there a slowdown in revenue growth?; 8) Are new, lower-cost products entering the market?; 9) Is government regulation changing in a manner adverse to the company?; 10) Are there increasing labor, government or foreign currency problems?; 11) Are the financials strong or weak, and is additional capital infusion required?

If some of the answers to these questions are unfavorable, the time may be appropriate to switch to a more promising situation.☐

MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

September 18-19 — AMA 1985 Political Education Conference, Washington, DC, contact: AMA Division of Political Education, 1101 Vermont Avenue, NW, Washington, DC 20005. (202)842-8442.

September 20 — Prescription Drug Diversion Statewide Conference, University of Michigan League Convention and Conference Center, Ann Arbor. Co-sponsored by MSMS and state and local government, professional and community organizations. Contact Sherry Wellman, MSMS headquarters.

September 20-22 — Conference on the Well-Being of Physicians, Amway Grand Plaza Hotel, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

October 2 — MSMS Practice Management Seminar, "Management and Marketing — Improving your Practice." Flint Sheraton Inn, contact: Kirk McMurray, MSMS headquarters.

October 9 — MSMS Practice Management Seminar, "Management and Marketing — Improving your Practice." Holiday Inn West, Livonia, contact: Kirk McMurray, MSMS headquarters.

October 16 — MSMS Practice Management Seminar, "Management and Marketing — Improving your Practice." Troy-Hilton Inn, contact: Kirk McMurray, MSMS headquarters.

October 17-19 — AMA National Medical Staff Conference, Sheraton Washington Hotel, Washington, DC, contact: Karen Prupes, (312)645-4418.

October 22 — "Onward to Lansing" Professional Liability Rally, Lansing, contact: Tom White, MSMS headquarters.

October 30 — MSMS Practice Management Seminar, "Management and Marketing — Improving your Practice." Amway Grand Plaza, Grand Rapids, contact: Kirk McMurray MSMS headquarters.

October 31-November 1 — AMA National Communications Workshop, Westin O'Hare Hotel, Chicago, contact: AMA Divison of Communications, 535 North Dearborn Street, Chicago, Illinois 60610.

November 12-13 — Health Policy and Quality of Care for Olde Americans, sponsored by the AMA, American Hospital Association, and the American Association of Retired Persons, Radisso Mark Plaza Hotel, Alexandria, Virginia, contact: Pat Clark (312)645-4497.

November 20 — MSMS Practice Management Seminar, "Management and Marketing — Improving your Pracitce." Battle Creek Stouffer's Inn, contact: Kirk McMurray, MSMS headquarters.

November 21 — MSMS Public Affairs/Leadership Conference, Long's Convention Center, Lansing, contact: Sherry Wellman, MSMS headquarters.

OTHER MEETINGS

August 15-18 — Michigan Ophthalmological Society 17th Annual Summer Conference, Grand Hotel, Mackinac Island, contact: Michigan Ophthalmological Society, 302 Eastland Center Professional Building, Harper Woods 48225 (313)839-3011.

September 9-11 — Promoting Family Planning: One Voice; One Goal, Ponchartrain Hotel, Detroit, contact: Family Planning Office, MDPH, (517)373-6790.

September 18 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola M. Heins (517)337-1351.

October 6 — Fall Brunch Meeting of Physicians of India Association, Troy Hilton, contact: Doctor Kothari (313)644-1269.

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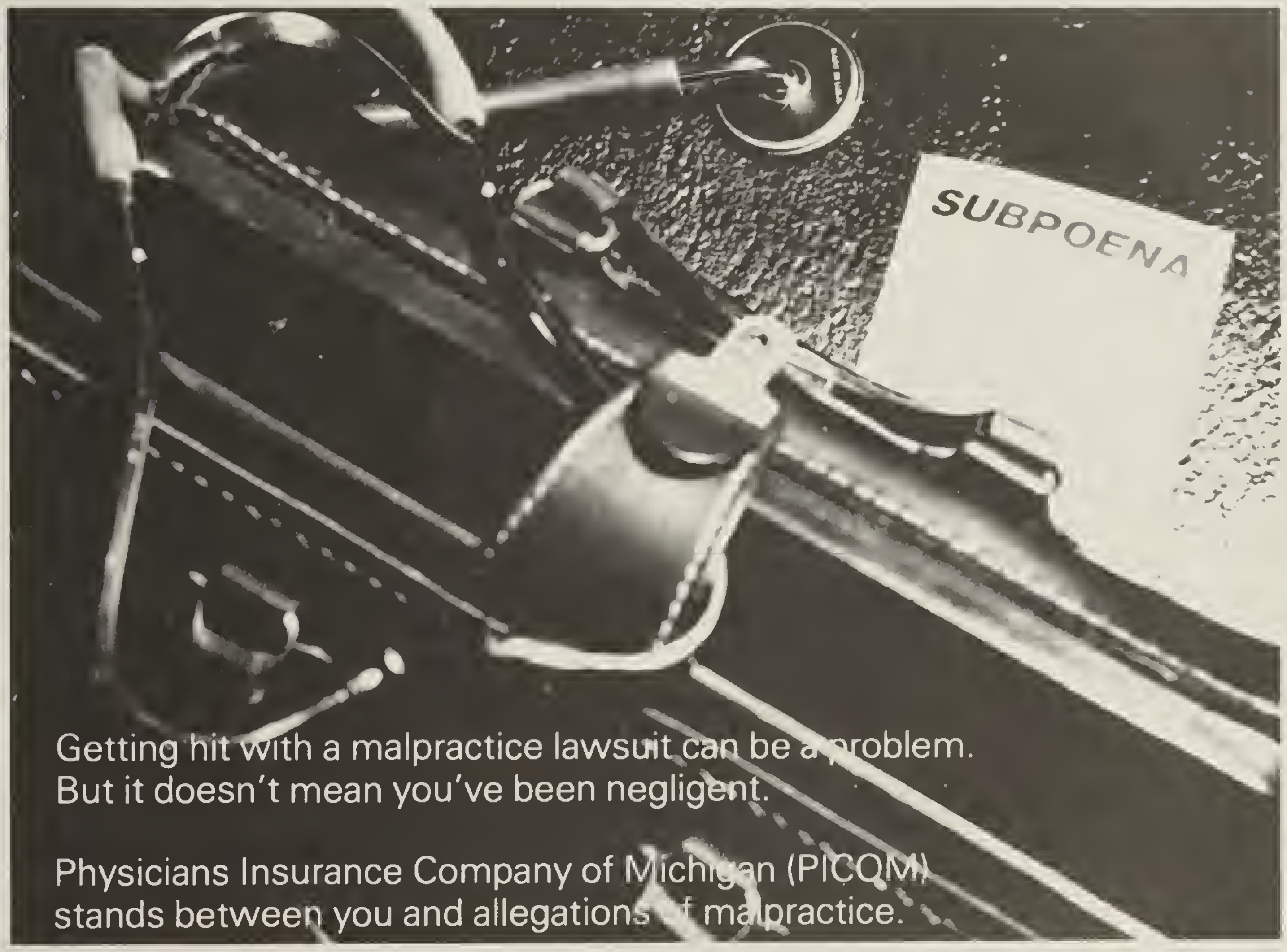

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Danish A. Alamy, MD — NEO
Two Hurley Drive
Flint 48504

Elie Banna, MD — OBG
36300 Van Dyke
Sterling Heights 48077

James W. Battagline, MD — TS
2799 W. Grand Blvd. Dept./Surg
Detroit 48202

Edward F. Bigsby, MD — EM
560 W. Mitchell
Petoskey 49770

Warren D. Bontrager, MD — FP
1260 S. Morenci
Mio 48647

Rex H. Brown, MD — GS
717 Trinway
Troy 48098

John R. Bruni, MD — AN
1 South Fifth St., Box 697
Niles 49120

Doyle E. Calley, MD — IM
525 Lafayette
Ionia 48846

I. Dale Carroll, MD — OBG
230 W. Oak St. #106
Fremont 49412

Vicki E. Chessin, MD — FP
160 Warwick
Alma 48801

Jay D. Collins, MD — IM/GE
337 E. Houghton Ave.
West Branch 48661

Steven M. Donn, MD — PD/NPM
5712 Woodridge Ct.
Ann Arbor 48103

Gary G. Doss, DO — ORS
1037 Water St., Box 5002
Port Huron 48060

Abdalla M. El Nass, MD—DR
130 Towner
Ypsilanti 48197

Curtis J. Finney, MD — OBG
3300 Burton, SE
Grand Rapids 49506

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13311 Wilshire
Detroit, MI 48213

Gobind L. Garg, MD — IM
13801 W. Nine Mile Rd.
Oak Park 48237

Ollie M. Gatewood, MD — FP
2412 R. T. Longway Blvd. #9
Flint 48503

Carol L. Hulett, MD — ORS
43201 Commons Drive
Mt. Clemens 48044

Jon M. Kaliszewski, MD — AN
1504 S. Huron
Tawas City 48763

Karl F. Kolbe, MD
44199 DeQuindre #304
Troy 48098

Leroy Lang, Jr., MD — IM
17320 Livernois
Detroit 48221

Nelson K. Lytle, MD — IM
19401 Hubbard Dr.
Dearborn 48126

Leo M. Maher, MD — N
21654 Hidden Rivers
Southfield 48075

Ira H. Mickelson, MD — OBG
6931 Leslie Crest Dr.
West Bloomfield 48033

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4201 St. Antoine 7C
Detroit 48201

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4076 Waterwheel
Bloomfield Hills 48013

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19401 Hubbard Dr.
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8200 E. Jefferson #608
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1528 Brentwood Dr.
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2856 Central
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21319 Kingsville #203
Harper Woods 48225

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Pontiac 48053

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2799 W. Grand Blvd.
Detroit 48202

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425 E. Washington
Ann Arbor 48104

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43201 Commons Dr.
Mt. Clemens 48044

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5333 McAuley Dr. R6115
Ypsilanti 48197

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4007 Orchard Drive
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18101 Oakwood Blvd.
Dearborn 48124

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32336 Concord Dr. #19-B
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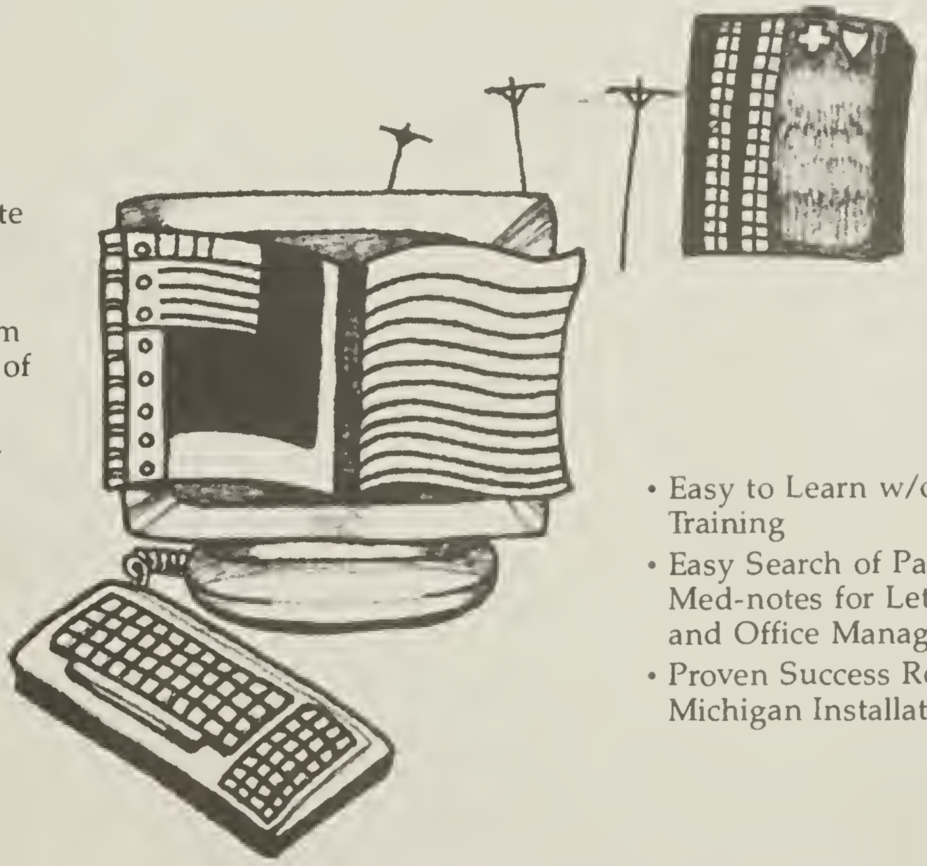

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DEATHS

Byron A. Andreou, MD
Grosse Pointe Farms
Doctor Andreou died May 16 at age 57. He graduated from the University of Salonika in Greece. He specialized in pediatrics at Detroit's Harper Hospital and St. John's Hospital in Harper Woods.

Jacob Bruggema, MD
Evart
Doctor Bruggema died at age 80 on April 28. He graduated from the University of Michigan Medical School in 1930. He interned at St. Mary's Hospital in Grand Rapids, then established a practice in general surgery.

Lloyd A. Campbell, MD
Saginaw
Doctor Campbell died May 2 at the age of 89. He attended Northwestern University Medical School in Chicago where he specialized in therapeutic radiology. He was on the medical staff at both Saginaw General Hospital and St. Mary's Hospital.

Joseph Carp, MD
Detroit
Doctor Carp died on May 7 at the age of 76. He graduated from Wayne State University School of Medicine in 1939. He practiced in Hamtramck at St. Francis Hospital and in Detroit at Brent General and Women's hospitals.

Owen Deuby, MD
Novi
Doctor Deuby died May 10 in Sun City, Arizona, where he had lived since 1982. A 1939 graduate of the Wayne State University School of Medicine, he had been a specialist in obstetrics and gynecology for 34 years before retiring in 1980.

Alfred Goldfaden, MD
Detroit
Doctor Goldfaden died May 11 at age 64. He graduated from Wayne State University Medical School in 1950, and was known as a willing community voluntee and philanthropist.

James E. Harryman, MD
Muskegon
Doctor Harryman died June 9 a the age of 69. Until his 1983 retirement, Doctor Harryman had been an obstetrician/gynecologist. He was a 1941 graduate of the University of Michigan Medical School.

James R. Marshall, MD
Grosse Pointe Park
Doctor Marshall died April 19 at age 59. He specialized in ophthalmology and was a 1951 graduate of the University of Michigan Medical School.

Walter E. Mercer, MD
Benton Harbor
Doctor Mercer died May 23 afte 50 years of practice. He studied medicine at the University of Buffalo and practiced at Mercy Hospital in Benton Harbor and at Memorial Hospital in St. Joseph.

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rthur H. Mollman, MD
rand Rapids

octor Mollman died May 15 at ıe age of 99. He received his ıedical training at the universities f Heidelberg, Munich and Wur-urg in 1920. A general surgeon, e practiced in Grand Rapids om 1926 until he moved to exas in 1949. He returned to ırand Rapids in 1956 and prac-ced until his retirement in 965.

lermann K. B. Pinkus, MD
lonroe

)octor Pinkus died May 18 at the ge of 79. He was a well-known lermatologist who had published ıore than 180 works. He raduated in 1929 from the Iniversity of Berlin.

Vilma C. W. Rorich, MD
attle Creek

)octor Rorich died May 15 at age 38. She was born in Kalamazoo nd was a graduate of the University of Michigan School of Medicine. She had served on the board of directors of the Michigan Council on Family Relations.

William J. Scott, MD
Grosse Pointe Woods

Doctor Scott died January 12 at the age of 98. He graduated from Johns Hopkins University School of Medicine in 1922. He was a pediatrician affiliated with St. John Hospital, Cottage Hospital, and Bon Secours Hospital.

Eugene M. Shafarman, MD
Palm Springs, California

Doctor Shafarman, formerly of Detroit, died February 11 at the age of 79. He graduated from University of Michigan Medical School and was a Detroit-area physician for nearly 50 years. He was a long-time staff member of Hutzel Hospital and retired from practice in 1982.

Daniel M. Stiefel, MD
Detroit

Doctor Stiefel died April 22 at age 89. He graduated from John Hopkins University School of Medicine in 1921, and was a full-time specialist in orthopedic surgery.

Chester E. Stellhorn, MD
Houghton Lake

Doctor Stellhorn died December 3 at age 84. He was a 1929 graduate of the University of Michigan. He was a practicing physician in an evangelical home for children and the aged.

John A. Valantiejus, MD
St. Joseph

Doctor Valantiejus died June 17 at the age of 63. He earned his MD degree from Loyola University in 1951. He volunteered his time and talents to the people of Haiti for 18 years.☐

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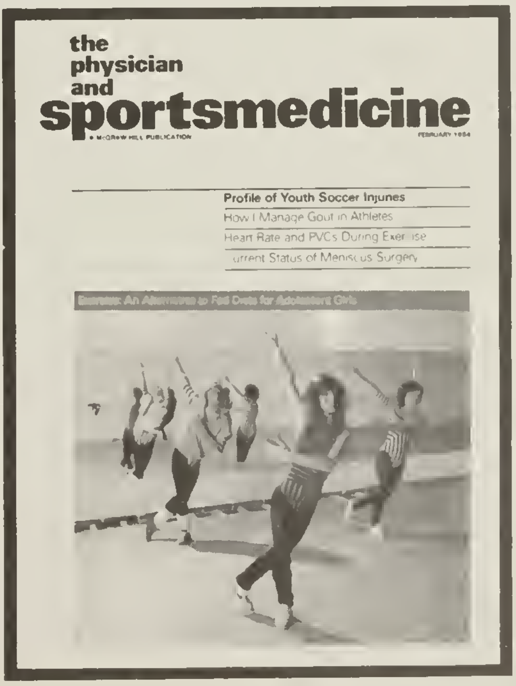
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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: September 10, Lipid Disorders: Insights Into A New Era. Location: Ingham Medical Center, Lansing. **Sponsor:** Postgraduate Medicine Custom Communications. **Contact:** Mrs. Agnes Bauman, 1221 Avenue, 41st Floor, New York, New York 10020. **Approved for:** 7 hours of Category I Credit.

Date: September 11 - Cancer Detection & Management: The Role of the Primary Physician. Location: Civic Center, Marshall. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category I Credit.

Date: September 12-14, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. Lovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Date: September 16-18, Trauma to the Hand: Diagnosis, Treatment and Functional Restoration. Location: Towsley Center, Ann Arbor **Sponsor:** American Society for Surgery of the Hand. **Contact:** ASSH, 3025 S. Parker Rd., Ste. 65, Aurora, CO 80014 (303) 755-4588. **Approved for:** 16.5 hours of Category I Credit.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 20, Reflections on Suicide and Suicide Prevention. Location: Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Western Michigan Psychological Association **Contact:** Nancy Petty (616)966-5600, ext.3594 **Approved for:** 6 hours of Category I Credit.

Date: September 25, Renal Problems for the Practicing Physician. Location: Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education & Michigan Nephrology Center. **Contact:** Arthur L. Riley, Michigan Nephrology Center, 1717 Shaffer St., Suite 210, Kalamazoo, (616)349-6759 Ext. 7140 **Approved for:** 7 hours of Category I Credit.

Date: September 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Colorado 80014 (303)755-4588. **Approved for:** 18 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295. **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 29-October 1, Tutorial on Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Human Medicine and Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: October 2, Coronary Artery Disease III. Location: St. John Hospital, Detroit. **Sponsor:** St.John Hospital. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 4, 6th Annual Trauma Day. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Bronson Methodist Hospital and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar Bouma (616)383-7576. **Approved for:** 7 hours of Category I Credit.

Date: October 4, Early Revascularization in Acute Myocardial Infarction. Location: Borgess Medical Center Auditorium. **Sponsor:** American Academy of Family Physicians, Kalamazoo Chapter of the Michigan Heart Association and Southwestern Michigan Area Health Education Center. **Contact:** Sharon Nocera (616)383-5940. **Approved for:** 6 hours of Category I Credit.

Date: October 4-6, Technological Advances and the Anesthesiologist. Location: Amway Grand Plaza, Grand Rapids. **Sponsors:** Michigan Society of Anesthesiologists and University of Michigan Department of Anesthesia. **Contact:** Caroline Rich, MSMS headquarters (517)337-1351 **Approved for:** 7 hours of Category I Credit.

Date: October 5-6, The Geriatrics Challenge/The Medical Response. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic. **Contact:** Kay Kelly, (616)348-4500. **Approved for:** 12 hours of Category I Credit.

Date: October 7-11, Tutorial and Workshop in the use of Immunocytochemistry and Electron Microscopy in Tumor Diagnosis. Location: Engineering Society of Detroit. **Sponsor:** Michigan Cancer Foundation. **Contact:** Jose Russo, MD, Michigan Cancer Foundation, 110 East Warren Avenue, Detroit 48201 (313)883-0710. **Approved for:** 44 hours of Category I Credit.

Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 20 hours of Category I Credit.

Date: October 11-13, Infectious Diseases "Hands-on Pelvic Workshop." Location: Grand Traverse Resort. **Sponsor:** MCAAP Committee on Adolescence and OMNI Corporation. **Contact:** Natalia M. Tanner, MD, 4727 St. Antoine, Hudsell Building, Suite 303, Detroit 48201 (313)831-1300. **Approved for:** 8 hours of Category I Credit.

Date: October 11-13, An Affordable Prescription: Knowledge, Comradery, and Relaxation. Location: Grand Traverse Resort. **Sponsor:** American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 18-19, A Practical Approach to Arthritis for Physicians. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Bronson Methodist Hospital. **Contact:** Chris Pearson, Southwestern Michigan Area Health Ed. Center, 1521 Gull Rd., Kalamazoo 49001 (616)383-6360. **Approved for:** 6 hours of Category I Credit.

Date: October 19, Common Problems with Coronary Artery Disease. Location: Somerset Inn, Troy. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076 (313)557-9500. **Approved for:** 7 hours of Category I Credit.

Date: October 21-25, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: October 23, The Second Annual Conference on Alcholism. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Cener, 1521 Gull Road, Kalamazoo. 49001. **pproved for:** 6 hours of Category I redit.

ate: October 23, Update on GYN-Onology. Location: St. John Hospital,Deoit. **Sponsor:** St. John Hospital. **Contact:** arol Mastroianni, Program Coordinator 313)343-3877. **Approved for:** 8 hours f Category I Credit.

ate: November 2, Women: Current sychoanalytic Views. Location: Hyatt egency, Dearborn. **Contact:** Michigan sychoanalytic Clinic 16310 West Twelve ile Road, Suite 204, Southfield 48075. 313)557-8633. **Approved for:** 6 hours f Category I Credit.

ate: November 7, Michigan Family ractice Research Day IX. Location: ichigan State University. **Sponsor:** ichigan State Family Practice. **Contact:** ouglas B. McKeag, MD, Chairman, B-00 Clinical Center, MSU, East Lansing 8824. (517)353-0770. **Approved for:** 0 hours of Category I Credit.

ate: November 7-9, ACLS - Advanced ardiac Life Support. Location: Genvieve . & Donald S. Gilmore Center for Health ducation, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education enter. **Cost:** $250. **Contact:** Cyndi ochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E. ovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Category I Credit.

Date: November 7-8, Recognition and Management of the Asphyxiated Newborn. Location: Towsley Center, Ann Arbor. **Sponsor:** Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Towsley Center Box 057, Ann Arbor, MI 48909 (313)763-1400 **Approved for:**14 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting, "From here to eternity." Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. 18 Category I Credits applied for.

Date: November 20, A Clinical Day on Alcoholism. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital, CME Committee. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 Category I Credits.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 23-25, Tutorial on Fundamental Principles of Manual Medicine as Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: December 2-6, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: February 12, 1986, Pediatric Neurology. Location: St.John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 12, 1986, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: April 16, 1986, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

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By Richard J. McMurray, MD

Come to Lansing October 22— show lawmakers the crisis is real

Save Tuesday, October 22 on your calendar. On that day, physicians from Copper Harbor to Flat Rock will have a unique opportunity to tell the legislature, the media and the people of Michigan that the professional liability situation has reached crisis proportions.

MSMS is coordinating a statewide rally at the Capitol that day—"Onward to Lansing"—to demonstrate organized medicine's deep concern, and to encourage lawmakers' careful consideration of our legislative package this fall. That package, now being finalized, is aimed at alleviating the crisis' myriad negative effects on physicians and on the delivery of medical care to our patients.

The MSMS Special Task Force on Professional Liability, headed by Lou Zako, MD, MSMS immediate past president, has worked diligently for months on a multi-faceted search for answers to this situation that you and I find perplexing and frustrating. The Task Force has made some important strides, and the reports have been encouraging. But now, you and I have an opportunity to participate in a highly tangible effort to get our message across. I urge you to come to Lansing October 22 in support of the medical profession and the concerns that we physicians have regarding our ability to serve the people of Michigan. We must articulate to the legislature our concern about this threat to the entire medical delivery system.

Carl A. Gagliardi, MD, chairman of the MSMS Board of Directors is spearheading this rally. He and Peter A. Duhamel, MD, chairman of the MSMS Hospital Medical Staff Section (HMSS), have developed this plan, an enhancement of a creative Wayne County Medical Society initiative, that will bring thousands of physicians to the steps of the Capitol.

A process

The goal of "Onward to Lansing" is *communication*. It is not intended to be a dramatic demonstration, a work stoppage, a strike. It *is* intended to be a way to draw attention to the serious professional liability situation in Michigan and to provide a stimulus for reform. It is part of a *process*—an evolution.

Logistical details about "Onward to Lansing" will be available to you soon from your local Hospital Medical Staff representative or chief of staff. And further information on transportation to Lansing and meetings with legislators is forthcoming in *Michigan Medicine*, *Medigram* and *MSMS Professional Liability Report*. Local planning teams, coordinated by the HMSS, are being asked to make arrangements to provide medical coverage for patients of physicians who attend the rally. The arrangements will be communicated to patients and the media to abate concerns about the availability of care that day, as well as to draw attention to the rally and our legislative package. Your county medical societies will assist with these activities.

Take a positive, tangible step toward alleviating this professional liability crisis. Take one day out of your busy schedule to support MSMS, your profession and your patients. Your participation can help ensure that the people of Michigan will continue to receive high quality medical care now and in the future.☐

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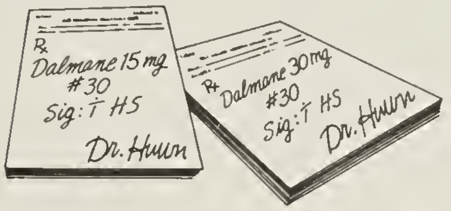

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MICHIGAN MEDICINE

September, 1985 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 84, No. 9

1985 MSMS Annual Scientific Meeting
November 12, 13 & 14

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A long, healthy life is everyone's wish . . . we all hope "heaven can wait" a little longer. Expert medical care can make that hope a reality, and your continuing medical education is a vital part of the process. So plan now to attend the MSMS 120th Annual Scientific Meeting.

This year's conference offers 55 contemporary courses for Category I CME credit, new educational activities designed to keep you up-to-date and more than twenty other special functions.

Register today . . . *prepare yourself to help people live longer, healthier lives. For the ones you help, "heaven can wait."*

1985 MSMS ANNUAL
SCIENTIFIC MEETING
November 12, 13 & 14
Hyatt Regency Dearborn

September 1985, Vol. 84, No. 9

MICHIGAN MEDICINE

About the cover: Life is full of changes . . . turning points that demand special attention and expert medical care. Be prepared to help your patients deal with those changes. Attend the MSMS 120th Annual Scientific Meeting. *Photo by Kim Kauffman*

Special Report

482 Everything you need to plan for the 1985 MSMS Annual Scientific Meeting is printed on pages 482-493 in this issue, including speakers, topics, times and places. You'll find information on special events, exhibits and lodging, as well as a registration form on page 493. Register early for the best course selection, *and* to better your chances of winning two free nights' lodging plus dinner for two! Annual Scientific Meeting Chairman C. Edward Cotton, MD, extends his personal invitation to you on page 522. Don't miss this opportunity to earn up to 18 quality Category I credits at an economical price.

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In next month's Michigan Medicine:

Three hundred million doses — that's the US Drug Enforcement Administration's estimate of the quantity of legally manufactured drugs being diverted to illicit channels for street use. Some officials suspect the problem is much greater than even that enormous estimate. The October issue of *Michigan Medicine* will shed light on the current situation in our state.

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Michigan Medicine, the official journal of the Michigan State Medical Society, i dedicated to provide useful information for Michigan physicians about actions o the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editori board of *Michigan Medicine* and advise the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or featur published in the pages of the journal. Th views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserve the right to accept or reject advertising copy. Products and services advertised *Michigan Medicine* are neither endorse nor warrantied by MSMS.

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or the AMA Presidency. I hope
he inspiring action of the Michi-
an State Medical Society will
ncourage other societies to
onsider the Foundation as an
ppropriate mechanism to ex-
ress support for their candidates
the future. Many thanks to
lichigan for adding so much to
he AMA-ERF ceremony and to
he medical school fund.

Rufus K. Broadaway, MD
President
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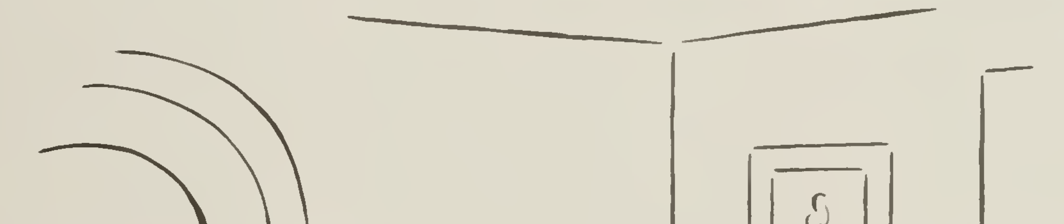
Rufus K. Broadaway, MD, president of the AMA Education and Research Fund (AMA-ERF) accepts a check from Richard J. McMurray, MD, left, then head of the Michigan Delegation to the AMA, and now MSMS president. The check represents donations to the fund from the delegation, Michigan county medical societies and other physician contributors in honor of the candidacy of John Coury, MD, Port Huron, for AMA president-elect. Delegation members and MSMS leaders chose to celebrate Doctor Coury's election victory by making a gift to the fund, at his urging.



"What a day I had! I covered for Dr. Browning, who covered for Drs. Raymond and Cassetti, who in turn were covering for Fisk, Linkman and Coy — "

By Sheri Greenhoe
Managing Editor

Picture yourself at the 1985 MSMS Annual Scientific Meeting

"From Here to Eternity," "The Turning Point," and "Heaven Can Wait" — they sound like answers to silver screen trivia questions, but they're not.

For our purposes, these popular movie titles describe stages in your patients' lives—youth, mid-life and the later years—*and* the new series of "alpha-omega" courses being offered at the 1985 MSMS Annual Scientific Meeting. The popular continuing medical education event will be held November 12-14 at the gracious and convenient Hyatt Regency Dearborn. This year, two sets of three courses will detail the progress of diabetes and pulmonary disease through the early, mid- and later years, providing physicians with a sequential picture of the diseases throughout a patient's lifetime.

C. Edward Cotton, MD, MSMS Annual Scientific Meeting chairman, is determined to make this *tenth* anniversary session the best CME event ever. Read his personal invitation to you in his President's Page column on page 522.

In addition to the new "alpha-omega" courses, many favorites from previous years will be offered: Basic Cardiac Life Support; Low Back Pain; The Dizzy Patient; Medical Ethics and dozens more. Read through the course descriptions in this Special Report and discover the wide variety of offerings. Then mark your choices on the registration form on page 493, and mail it to MSMS soon—you may win two free nights' lodging and dinner for two. Details about the drawing are printed below.

Register early and win!

Win a complimentary room for two nights and dinner for two during your Annual Scientific Meeting stay. All you have to do is make your room reservations early!

To be eligible, simply make your reservation prior to October 17 for the October 21 drawing. Room reservations must be made *direct* with the Hyatt Regency Dearborn; 1800 Michigan Avenue; Reservations Office; Fairlane Town Center; Dearborn, MI 48126. The telephone number of the hotel is (313) 593-1234. Indicate that you are attending the MSMS Annual Scientific Meeting to take advantage of the convention rate. You could win a free room for two nights and dinner at the exciting Giulio and Sons restaurant in the hotel.

After October 17, rooms are on an availability basis only.

More than just courses

You'll find there's lots more to the MSMS Annual Scientific Meeting than what's in the classroom. Many specialty societies and medical schools have planned special events and receptions. For example, the MSMS Committee on the Concerns of Women Physicians will hold a breakfast early Wednesday morning open to *all* interested women MDs. And non-members are especially encouraged to attend.

Seventy exhibitors will display and demonstrate products and services of interest to you throughout the three-day meeting. And your colleagues, encouraged by last year's successful debut, will once again present clinical posters that illustrate important medical advances.

A complete list of special events appears on page 492 of this Special Report.

Plan *now* to attend the 1985 Annual Scientific Meeting. Remember, early registration assures you the greatest course selection, and qualifies you for our free-room-and-dinner drawing.☐

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Tuesday morning, November 12

Basic Cardiac Life Support
(Repeated on Wednesday and Thursday mornings)
Robert K. Orr, Jr., DO

The course will include lectures and practical stations for teaching Basic Cardiac Life Support. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant.

Carcinoma of the Prostate: Current Management
Harold Perry, MD

Cancer of the prostate is the second most common malignancy in males. Diagnostic and prognostic studies will be discussed as well as the role of surgery, radiation therapy, hormone and cytotoxic therapy and results of treatment. The objectives of the course are to inform the attendee of 1) the methods of diagnosis, 2) staging and determination of prognosis, 3) options and results of treatment and 4) follow-up methodology.

Environmental Emergencies
Neal E. Little, MD

This course will discuss management of some of the common emergencies brought about by environmental elements. Topics will include: 1) bite-sting and anaphylaxis (a discussion of current therapy and considerations for de-sensitization), 2) current treatment, clinical manifestations and limitations of lab testing in carbon monoxide intoxication, 3) common clinical presentation, etiologic agents and current therapy in food poisoning, and 4) current diagnosis and treatment of acetaminophen overdose.

Evaluation and Treatment of Metastatic Colon Tumors in the Liver
Donald W. Weaver, MD

This course, designed for both surgeons and non-surgeons, outlines current treatment options for patients with liver metastasis from colorectal cancer. Using case reports and personal experience, each panelist will illustrate important features of the various treatment modalities with emphasis on the key factors in therapeutic decision-making. Recent surgical advances and current chemotherapy options as well as factors influencing survival will be discussed.

Hypertension and Aging
James R. Sowers, MD

This course will instruct primary and consulting physicians in various methods of managing and treating the unique aspects of hypertension in the elderly. We will review the epidemiology and pathophysiologic aspects of this problem, and also provide overview of geriatric renovascular hypertension isolated systolic hypertension.

Management of the Spinal Cord-Injured Patient in General Practice
Leonard F. Bender, MD

Using lecture, demonstration, and

Continued on page 484

Evans

Green

Gruskin

Ho

Hoff

Honet

Honicky

Kemink

Kim

Lewis, J

Lewis, V

Magdea

TUESDAY MORNING/Continued

case history, an interdisciplinary faculty will focus on urinary tract and bowel problems, spasticity, upper respiratory infections, autonomic dysreflexia, decubitus ulcers, pharmacotherapy, and psychosocial/sexual issues. Presenters also will review state-of-the-art treatment and assistance in the management of spinal cord-injured patients at a comprehensive rehabilitation hospital.

Occupational Health Concerns of the General Medical Community
Howard J. Sawyer, MD

Consisting of three segments, this lecture/discussion is for physicians of all specialties whose practices relate in any way to the diagnosis or treatment of occupational diseases and injuries. It will provide practical information on the health aspects of exposures to laser equipment, new imaging devices, waste anesthetics, ethylene oxide, chemotherapeutics and other agents, VDUs and infectious disease control which were extensively covered during the 1984 presentation.

Rheumatology 1985; Osteoporosis, Hyperuricemia and Gout
Joseph J. Weiss, MD

The first part of the session will provide the primary physician with an update on current concepts in therapy for osteoporosis. The problems of diagnosis and treatment will be highlighted by case presentations accompanied by roundtable discussion of each case. Aspects of osteoporosis to be considered will include appropriate laboratory examination, role of radiology, steriod-induced osteopenia, and the place of calcium both in its medical and other forms. The second part of the program will discuss hyperuricemia and gout. The subject will be introduced by an overview of urate metabolism, followed by a discussion of gout and its imitators. A roundtable discussion will follow on hyperuricemia.

Type I Diabetes and Related Problems
Michael Netzloss, MD and William B. Weil, Jr., MD

This course is planned as the first of a three-part "alpha-omega" session on diabetes. This course will provide physicians caring for young patients with insulin-dependent diabetes mellitus with a management plan for long term care of such patients. The current procedures for determining insulin requirements, use of home glucose monitoring, assessment of control using glycosolated hemoglobin, patient education and the management of intercurrent illness, contraception, behavioral problems and adolescent autonomy will be defined.

Tuesday afternoon, November 12

Clinical Applications of Magnetic Resonance Imaging
William Martel, MD

This course will provide practical information on clinical applications of magnetic resonance imaging (MRI) which will be helpful to physicians in clinical practice. MRI is particularly valuable in a variety of neurologic conditions. More recently, attention has been turned to its use in a number of other diseases affecting mediastinum, abdomen, pelvis, musculoskeletal and cardiovascular systems. The current role of MRI in various clinical situations compared to other diagnostic modalities will be demonstrated.

Focus on Aging: Depression
Sumer Verma, MD

Loss is a predominant theme in characterizing the emotional experiences of the aged. Changes in mood frequently accompany such losses. The practitioner may experience some difficulty differentiating between despondency transiently experienced by the aging and depression. This, course will, through panel discussion, cover etiology, identification, and treatment of depression from the biological, psychodynamic and social viewpoints.

Martel

Migdal

Morrell

Nagle

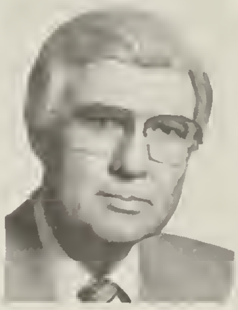
Netzloff

Peppard

Perry

Polley

Royer


Sawyer

Sobel

Sowers

Headache, TMJ Syndrome and Sinus Disease: Which Is Your Patient's Problem?
John L. Kemink, MD

In the family practice and specialist office setting, chronic pain syndromes of the head and neck are common. This course will discuss the identification and treatment of these chronic pain syndromes, the physical examination, and diagnostic testing.

Low Back Pain: A Practical Treatment Approach
Robert E. M. Ho, MD

Previous courses have stressed surgical management. This course will stress a practical approach to include diagnosis, management of initial low back pain, decision-making steps in determining care programs of more complicated injuries. At the conclusion of this course each participant will be able to distinguish mechanical low back pain from lumbar disc herniation or other surgical lesions, initiate a comprehensive treatment program to include physical therapy, and design criteria for treatment failure requiring subspecialty referral. The course is timely because of our current emphasis on efficient utilization of health services, criteria for admission to the hospital as regards back problems, and DRGs.

Lower Extremity Sports Injuries: Identification and Management
Jerome V. Ciullo, MD

This course is intended for the family practitioner or internist who cares for the high school athlete. Initial identification, management and rehabilitation of specific problems related to soft tissue overuse, the ankle, the knee and the foot will be addressed.

Management of Common Pain Syndromes
Eli M. Brown, MD

A panel of pain specialists will discuss the diagnosis and management of commonly encountered pain problems through the use of nerve blocks, thermography, physiatry and psychiatric modalities. Pain problems to be considered include reflex sympathetic dystrophy, herpes zoster, back pain, neck pain, and pain secondary to malignant disease.

Organ Transplantation and the Community Physician
Darrell Campbell, Jr., MD

This course is intended to convey to primary physicians, using a series of short lectures, the current indications for various types of organ transplants. One segment will concentrate on problems encountered in patients taking chronic immunosuppressive medication, including cyclosporine, while another will deal with some of the moral dilemmas associated with cadaveric organ donation.

Pulmonary Disease in Pediatrics
Richard E. Honicky, MD

This course is planned as the first of a three-part "alpha-omega" session on pulmonary disease. Through three didactic sessions, physicians will learn about the evaluation of coughing and wheezing children and medications that may be prescribed. There will be three 45-minute lectures followed by question and answer period. Upon completion of this course, physicians will understand evaluation and use of medications specialists may prescribe.

Selected Topics in Nuclear Medicine for the Practicing Physician
Conrad E. Nagle, MD

This course will provide practical information to primary care practitioners, specialists, and allied health professionals about the indications, uses, and cost-effectiveness of bone imaging in sports medicine and oncology. It will provide practitioners with background information (requested by patients) about radiation in the hospital and non-hospital environment.

Continued on page 486

Stanley

Swanson

Taylor

Verma

Victor

Ward

Weaver

Weil

Weiss

Wednesday morning, November 13

Basic Cardiac Life Support
Robert K. Orr, Jr., MD

(See Tuesday morning course description)

Clinical Approach to Advanced Pediatric Life Support
Theodore Z. Polley, Jr., MD and Joseph R. Custer, MD

A series of lectures will be utilized to provide a practical review of advanced pediatric life support. Emphasis will be placed on the basics of the evaluation of trauma in the pediatric age group as well as cardiopulmonary arrest and acute neurologic insult with attention to stabilization and resuscitation. In addition, there will be case presentations and discussion with a practical, clinical approach and encouragement of audience participation.

Common Surgical Problems in Infants and Children
Arnold G. Coran, MD

This course will cover surgical problems in infants and children through three one-hour lectures. The lectures will emphasize the types of diseases seen in a general physician's office. Routine diagnostic work-up and subsequent management also will be covered.

Diabetes in the Mid-Years
George L. Royer, Jr., MD

This course, planned as the second part of a three-part "alpha-omega" session on diabetes, will examine the diagnosis and classification of diabetes in the mid-years. Treatment will be disscussed with emphasis on Type II disease. Diabetes in pregnancy will be explored. Some discussion of diabetes in the mid-years will address complications of the disease.

Evaluation and Treatment of the Dizzy Patient
Sean B. Peppard, MD

This course is designed to present the practitioner with a rational scheme for working-up and managing the dizzy patient. Emphasis will be placed on history-taking, the differential separation of non-vestibular disease and straightforward laboratory methodology. Discussion of management will be facilitated by videotape and a panel discussion of select representative cases.

Gait Problems — A Pathway to Diagnosis
Joseph C. Honet, MD

This course will provide primary care physicians with practical information about gait problems in adult patients. The course will utilize a live model for demonstation of the physical examination of gait and live patient demonstrations for abnormal gait seen in the course of a medical practice. There will be an emphasis on neurological, rheumatological and physiatric gait problems. Upon completion of the course, the attendee should understand some of the characteristics of gait and practical points of physical examination, and be cognizant of the differential diagnosis of gait problems.

Industrial Injuries: Evaluation, Prevention & Management
Donald M. Ditmars, Jr., MD

Dysfunction syndromes associated with the energy field are being recognized as causing significant hand morbidity. The pathophysiology, etiology and treatment will be presented with emphasis on carpal tunnel syndrome. The interface of hand surgery will be explored with experts from both fields.

Melanoma & Precursor Lesions — Advances in the 80s
Neil A. Swanson, MD

This course will detail current concepts of pigmented lesions and melanoma. Precursor lesions, recognition, significance, and management will be presented by a guest expert. Malignant melanoma will be discussed, including clinical recognition, biopsy techniques, histology and treatment. The multidisciplinary approach to the disease will be emphasized, as will treatment controversies, including margins and lymph node dissection in Stage I disease, and therapeutic advances in advanced disease.

New Aspects in Hormone Therapy for Women
Vivian M. Lewis, MD

This course will provide a comprehensive review of current concepts in diagnosis and treatment of hormone-deficient women. There will be four lectures of forty minutes and a panel discussion of questions generated from the audience. The course will identify indications for therapy, psychological issues encountered with hormone therapy and prevention of osteoporosis and other complications.

Treatment Options for Malignant Brain Tumors
Julian T. Hoff, MD

This course will focus on state-of-the-art methods for dealing with malignant brain tumors. Special attention will be devoted to gliomas and medulloblastomas. Evidence for improving results using surgery, radiation therapy and chemotherapy will be presented. Practical, social and ethical considerations will be addressed.

Wednesday afternoon, November 13

Allergy and Asmtha Update
Ilie Magdea, MD

This course will allow primary and consulting physicians to review basic knowledge and to gain updated information regarding symptomatology, diagnosis and treatment of allergic and non-allergic rhinitis, bronchial asthma and anaphylactic reactions.

Chronic Abdominal Pain
James E. Mayle, MD

This course will review the anatomical and pathophysiological basis for abdominal pain, explore psychosocial components of chronic pain and present an internist's, surgeon's, and psychiatrist's approach to the problem. Actual cases will be presented for panel and audience discussion.

Cumulative Trauma Disorders and Ergonomics in Industry
Dean S. Louis, MD

The objectives of this course are to teach elements which lead to cumulative trauma disorders in industry from the medical, business and union viewpoints and to relate what steps can be taken to reduce the problem. We will present data from various viewpoints and emphasize that surgery is rarely a solution, but that job rotation and other considerations usually provide the best results.

Afternoon courses run from 1:30-5 pm with half-hour break

Industrial Support of Medical Research and Treatment in Surgery
Donald M. Ditmars, Jr., MD

Dysfunction syndromes associated with the energy field are being recognized as causing significant hand morbidity. The pathophysiology, etiology and treatment will be presented with emphasis on carpal tunnel syndrome. The interface of hand surgery will be explored with experts from both fields.

Infectious Illness in Children
Alan B. Gruskin, MD

The comparative pharmacology and therapeutic uses of new antibiotics with possible broad clinical use in children will be discussed. The epidemiology of infections in day-care centers, and strategies for their prevention will be reviewed. The roles of the newly-available vaccine and other approaches in preventing haemophilus influenzae disease will be addressed. The principles of oral rehydration therapy and its application to treating diarrheal disorders in children will be reviewed.

Neurological Problems of General Interest and Frequent Encounter
Raymond B. Bauer, MD

This course will provide primary and consulting physicians with the most recent information concerning two of the most frequently encountered neurological problems: strokes and movement disorders. Emphasis will be placed on asymptomatic neck bruits, asymptomatic carotid stenosis, managment of TIAs and diagnosis and management of Parkinson's disease and other movement disorders.

Occupational Lung Disease
Lyle D. Victor, MD

This course is planned as the second of a three-part "alpha-omega" session on pulmonary disease. Inhalation of toxic substances in the workplace is a major cause of occupational lung injury. Practicing physicians need a thorough understanding of pulmonary disorders caused by inhalation for effective diagnosis and treatment and litigation in their patients. This course in occupational lung disease proposes to give an overview of the most common pulmonary injuries in the workplace.

Continued on page 488

Physician's Role in Diagnosis and Care of the Sexually Abused Child
Barbara Meyer Lucas, MD

This course will provide practical information regarding the diagnosis, medical management, and subsequent inter-agency follow-up of the sexually abused child. Through the use of slides and actual case histories, the seminar will cover: 1) guidelines for diagnosis and treatment of the chronic and acutely assaulted child; 2) interviewing techniques for history-taking from the sexually abused child; 3) legal responsibilities of the physician; and 4) guidelines for physicians called to appear in court as experts in suspected sexual abuse cases. Videotaped interview with children illustrating the use of anatomically correct dolls will be featured.

Recurrent Urinary Tract Infections Update
Ananias C. Diokno, MD

This course is designed to update practitioners in the latest trends in the pathogenesis, evaluation and management of patients with recurrent urologic infections. Specifically, problematic infections of the urinary tract in children and women, and of the genital tract in males will be presented. The choice of antibacterial preparations for specific urinary tract infections also will be discussed.

What's New in Dermatology
Neil A. Swanson, MD

Utilizing a short lecture format, this course will serve to update the practicing physician in several areas of dermatology. Specifically, changing concepts regarding melanoma and precursor lesion management will be discussed. The malpractice changes and outlook will be presented. The course will end with a series of "What's New" lectures by experts in their field, including alopecia, therapeutics, atopic dermatitis and clinical research.

Thursday morning, November 14

Basic Cardiac Life Support
Robert K. Orr, Jr. MD

(See Tuesday morning course description)

Child Psychiatry: An Update in Common Disorders
Michael D. McManus, MD and Norman E. Alessi, MD

The course will focus on three areas: attention deficit and behavioral disorders in childhood; depression and suicide in children and adolescents; and the psychiatric sequelae of physical and sexual abuse. One hour will be devoted to each topic and will include a slide presentation, videotaped clinical material and a discussion of treatment with an emphasis on the use of psychopharmacologic agents.

Morning courses run from 8:30-Noon with half-hour break

Diabetes in the Elderly
George L. Royer, Jr., MD

This course, planned as the last of a three part "alpha-omega" session on diabetes, will discuss the care of diabetes in the elderly as it relates to therapy and therapy of the complications of diabetes. Special attention will be given to cardiovascular, peripheral vascular and neurologic problems.

Evaluation and Treatment of the Painful Ischemic Lower Extremity
James C. Stanley, MD

This course will provide attendees with information to: 1) develop a differential diagnosis for exercise-related leg pain and cutaneous ulcers; 2) define the natural history of extremity arterial disease; 3) understand the basis for exercise programs and drug therapy in treating lower extremity ischemia; and 4) recognize the appropriate role of percutaneous transluminal angioplasty and bypass surgery in treating advanced ischemic disease.

Genetics Before and After Birth
Mark I. Evans, MD

This course will review basic genetic principles and how they have been applied to the prenatal diagnosis of genetic disorders. The course will emphasize the application and indications for newly available techniques, both pre-and post-natally. The emerging field of fetal therapy, i.e., both the surgical and medical treatment of the fetus in utero, will be discussed along with the significant ethical implications.

The Retina and Kidney—Diabetic Weathervanes
Frederick W. Bryant, MD

This course is designed to update general physicians and others on the current status of diabetic end-organ changes. While focusing on the retina, it will discuss pathogenesis of these changes in the kidney as well. Age of onset, duration and crisis factors (such as pregnancy) strongly influence the appearance and advance of vascular disease in diabetes. Retinopathy and nephropathy are important indicators of this process. This course will discuss diagnostic and prognostic retinal clues and will suggest the best time for inspection, referral, follow-up and treatment.

Update in Office Infectious Diseases

Jack D. Sobel, MD

This course will review for primary physicians and consultants the clinical manifestations and recent advances in diagnosis and treatment of sexually transmitted diseases and AIDS, as well as providing an update on current immunization practice. Lectures will include case presentation, numerous slides of clinical disease, as well as discussion of diagnostic and therapeutic dilemmas.

Thursday afternoon, November 14

Cataracts: Concepts and Complications

Frederick W. Bryant, MD

This advanced course is for specialists in ophthalmology. This course will emphasize recent innovations in cataract surgery and the relationship between operative complications and serious post-operative complications. IOL design considerations which impact on the final results in cataract surgery will be discussed. Special emphasis will be placed on cystoid macular edema and its relationship to IOL type, pre- and post-operative pathology and surgical technique.

Inflammatory Bowel Disease

Hans J. Stein, MD

This course is designed to provide the primary care physician with current concepts in the diagnosis, medical and surgical management of inflammatory bowel disease. There will be four 30-minute lectures followed by a panel discussion.

Medical Ethics: The Physician as Gatekeeper

Howard Brody, MD, PhD

Cost containment measures, including DRGs and prepaid health plans, confront the physician with the dilemma between serving society by containing the cost of care, perhaps at the expense of the individual patient, and serving as patient advocate to insist upon high quality care for everyone regardless of cost. A panel will explore the ethical and legal issues involved in this dilemma. A videotape documentary will be used to highlight problems facing hospital administrators, physicians and the community about emphasis on cost containment and for-profit medicine and its impact upon care of the poor and elderly. Ethical standards to help the medical profession and the individual practitioner cope with the cost containment environment will be proposed.

All 55 courses offer 3 hours each of Category I credit

Medical Evaluation for Disability Claims

Luke Y. Kim, MD

This course will provide a general approach for physicians who, at any time in their professional careers are requested to perform medical examinations of disability claims. Specific areas to be discussed will be the credibility of the medical profession when its members are involved in medical evaluation for disability claims, the improvement in quality of the performance of physicians engaged in medical evaluations for disability claims, and the improvement of the medical-legal interface in this area.

Multiple Sclerosis: Update on Diagnosis and Treatment

Ronald S. Taylor, MD

This course will present information useful to the clinician on the diagnosis, treatment and follow-up care of the person with multiple sclerosis. The panel discussion participants will be persons with multiple sclerosis to better acquaint the treating physician with the problems of daily living and the medical care needs for this population.

Nephrology for the Eighties

Stephen D. Migdal, MD

This course will provide the primary physician and internist with a review of current concepts of pathophysiology, diagnosis and management of the following common nephrologic problems: renal calculi; proteinuria and the nephrotic syndrome; hematuria; the role of analgesics and anti-inflammatory drugs in renal disease. The practical aspects of diagnosis and management as well as the indication for referral will be addressed.

Neurological Examination: Methods and Interpretation

Roger M. Morrell, MD, PhD

The clinical neurological examination will be extensively reviewed. Emphasis will be placed on the differences between a "screening" (minimal acceptable) examination and selective expansion of the examination in particular clinical settings. Internists and family physicians who see adults with neurological problems will learn more about how to perform and interpret the neurological examination.

Pulmonary Disease in the Elderly

Joseph C. Ward, MD

This course is planned as the last of a three-part "alpha-omega" session on pulmonary disease.

Continued on page 490

The aim of this course will be to acquaint physicians with the differential diagnosis of airflow obstruction in the elderly as well as the natural history and medical management of COPD. Some attention also will be directed to identifying the high risk individual in mid-life. There will be a thorough discussion of the role of pulmonary rehabilitiation in improving the quality of life for the elderly.

Complete and return registration form on page 493

Sexual Myths and Marital Counseling
Sander J. Breiner, MD

This course is for the primary physicians, ob/gyns, and urologists. It will provide practical information on diagnosis and treatment of common problems they see daily. It will address sexual myths and misconceptions (genital size, genital fit, physical positions, orgasm, pornography); marital problems (stress, sexual fantasies, post-honeymoon, pregnancy, baby-runs-the-world, 20-years-and-out, retirement, illness); and marital counseling (techniques for diagnosing and treating, couples homework, rules of how to fight in marriage).☐

Plan to visit these firms' exhibits

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting Nov. 12-14 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be awaiting the opportunity to discuss with physicians the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the ASM and is the site of registration for all courses and special events. In addition, the deli luncheons offered by MSMS to all ASM participants, and the clinical poster presentations will be in the exhibit area.

To help MSMS members plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

Pharmaceuticals

Ayerst Laboratories
Boehringer Ingelheim
Glaxo, Inc.
Hoeschst-Roussel Pharmaceutical
Key Pharmaceuticals
Merck Sharp & Dohme
Merrell Dow Pharmaceuticals
Reed & Carnrick
Smith Kline and French Laboratories
Syntex Labs, Inc.
The Upjohn Company
Wyeth Laboratories

Clinical Laboratories
Advance Medical & Research
Health Care Clinical Laboratory, Inc.
Smith Kline Bio-Science Laboratories
Vascular Studies, Inc.

In-Office Equipment and Support
Advance X-Ray
Brentwood Instruments
Cellular One
Cryomedics, Inc.
Firestone X-Ray Corp.
Metropolitan X-Ray Sales
Mobiltronics, Inc.
T-Com, Inc.
White & White, Inc.

Patient Home Care
American Orthopedic Service
Glasrock Home Health Care
Professional Breathing Associates
Southfield Rehabilitation Center
Support Systems International, Inc.
Total Therapy Management
Upjohn Healthcare Services

Computers/Computer Services
Automated Business Consultants
Bennethum Computer Systems
Compu Servis, Inc.
Data Script
Diversified Technologies Automated Input
Diversitec
Executive Business Systems
Interface Electronics
Macatawa Professional Systems
Medical Billing Service
Medical Data Sevices
Medical Information Systems, Inc.
Medical Practice Management System
Professional Computer Management, Inc.
Professional On-Line
Professional Practice Sales
Rollins Medical Systems
Unique Software

Educational Resources
Encyclopedia Britannica, U.S.A.
Health Professionals Medical Books
J.B. Lippincott Company
W.B. Saunders Company

Protection
Blue Cross Blue Shield
Comerica, Inc.
First Heritage Corporation
First of Michigan Corp.
E.F. Hutton
The Medical Protective Company
MI Physicians Mutual Liability Company
Physicians Insurance Co. of MI
Stratton-Cheeseman & Assoc., Inc.

Career
Summit Health Ltd.
U.S. Air Force

Other Exhibitors
Air Ambulance International
Havenwyck Hospital
Michigan Ophthalmological Society
Social Security — Disability Determination Services

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal /10 mg Oral /25 mg Oral
Methyltestosterone U.S.P. Tablets

ANDROID® /F
Fluoxymesterone U.S.P. Tablets, 10 mg

SPECIAL REPORT

At-a-Glance Schedule of Special Events

Tuesday, November 12	7:30 AM	Great Lakes Exhibit Center Open
	12 Noon	Luncheon/Board Meeting Michigan Occupational Medical Association
	4:30 PM	Reception and Presentation Clinical Posters
	5:30 PM 6:00 PM	Business Meeting Reception and Dinner Michigan Otolaryngological Society
	6:00 PM	Reception and Dinner Michigan Occupational Medical Association
	6:00 PM	Open Reception "Meet the Dean" University of Michigan Medical School
	6:30 PM	Reception and Dinner Michigan College of Nuclear Medicine Physicians
	7:00 PM	MSMS/PSG Seminar "Make Your Pension Plan Work As Hard As You— A Physician's Guide to Professional Investment Management"
Wednesday, November 13	7:30 AM	Great Lakes Exhibit Center Open
	7:30 AM	Women Physician's Breakfast Sponsored by the MSMS Committee on Concerns of Women Physicians—
	9:00 AM	Meeting and Luncheon Michigan Allergy Society
	11:30 AM	Luncheon, "The Impaired Woman Professional" Michigan Psychiatric Society Committee on Women's Issues
	12 Noon	Luncheon Specialty Society Presidents
	12 Noon	Luncheon Michigan Society of General Surgeons
	12 Noon	Business Meeting, Wine & Cheese Reception, Michigan Academy of Plastic Surgeons
	3:00 PM	Board Meeting Michigan Orthopaedic Society
	4:30 PM	Reception and Presentation Clinical Posters
	5:30 PM	Reception Jefferson Medical College Alumni
	6:00 PM	Reception and Dinner Michigan Branch, American Urological Association, Inc.
	6:00 PM	Reception and Dinner Michigan Orthopaedic Society
	6:00 PM	Reception Wayne State University Medical Alumni
Thursday, November 14	7:30 AM	Great Lakes Exhibit Center Open
	5:00 PM	Executive Committee Meeting
	6:00 PM	Reception and Dinner Michigan Ophthalmological Society
	6:30 PM	Reception and Dinner Michigan Society of Colon and Rectal Surgeons

PLEASE SEND ENTIRE
PAGE WITH CHECK

1985 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

l courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

ESDAY MORNING, NOV. 12

30 to Noon, including break)
rite 1 in blank for first choice and 2 for second choice)

- ____ Basic Cardiac Life Support
- ____ Carcinoma of the Prostate: Current Management
- ____ Environmental Emergencies
- ____ Evaluation and Treatment of Metastatic Colon Tumors in the Liver
- ____ Hypertension and Aging
- ____ Management of the Spinal Cord-Injured Patient in General Practice
- ____ Occupational Health Concerns of the General Medical Community
- ____ Rheumatology 1985: Osteoporosis, Hyperuricemia and Gout
- ____ Type I Diabetes and Related Problems

ESDAY AFTERNOON, NOV. 12

30 to 5:00, including break)
rite 1 in blank for first choice and 2 for second choice)

- ____ Clinical Applications of Magnetic Resonance Imaging
- ____ Focus on Aging: Depression
- ____ Headache, TMJ Syndrome and Sinus Disease: Which is Your Patient's Problem?
- ____ Low Back Pain: A Practical Treatment Approach
- ____ Lower Extremity Sports Injuries: Identification and Management
- ____ Management of Common Pain Syndromes
- ____ Organ Transplantation and the Community Physician
- ____ Pulmonary Disease in Pediatrics
- ____ Selected Topics in Nuclear Medicine for the Practicing Physician

The MSMS Committee on CME Programming, an rganization accredited by the MSMS Committee n CME Accreditation, certifies that this activity meets the criteria for a maximum of 18 credit hours n Category I toward the requirements for Michigan elicensure and of the Physician Recognition ward of the AMA, provided it is completed as designed.

Please check the courses you wish to attend. In each case, _please indicate a second choice_ should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/17/85 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

WEDNESDAY MORNING, NOV. 13

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

- ____ Basic Cardiac Life Support
- ____ Clinical Approach to Advanced Pediatric Life Support
- ____ Common Surgical Problems in Infants and Children
- ____ Diabetes in the Mid-Years
- ____ Evaluation and Treatment of the Dizzy Patient
- ____ Gait Problems – A Pathway to Diagnosis
- ____ Industrial Injuries: Evaluation, Prevention & Management
- ____ Melanoma & Precursor Lesions – Advances In the 80's
- ____ New Aspects in Hormone Therapy for Women
- ____ Treatment Options for Malignant Brain Tumors

WEDNESDAY AFTERNOON, Nov. 13

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

- ____ Allergy and Asthma Update
- ____ Chronic Abdominal Pain
- ____ Cumulative Trauma Disorders and Ergonomics In Industry
- *____ Industrial Support of Medical Research and Treatment in Surgery
- ____ Infectious Illness in Children
- ____ Neurological Problems of General Interest and Frequent Encounter
- ____ Occupational Lung Disease
- ____ Physician's Role in Diagnosis and Care of the Sexually Abused Child
- ____ Recurrent Urinary Tract Infections Update
- ____ What's New in Dermatology

THURSDAY MORNING, NOV. 14

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

- ____ Basic Cardiac Life Support
- ____ Child Psychiatry: An Update in Common Disorders
- ____ Diabetes in the Elderly
- ____ Evaluation and Treatment of the Painful Ischemic Lower Extremity
- ____ Genetics Before and After Birth
- ____ The Retina and Kidney – Diabetic Weathervanes
- ____ Update in Office Infectious Diseases
- *____ What's New in Cardiac Surgery

THURSDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

- *____ Cataracts: Concepts and Complications
- ____ Inflammatory Bowel Disease
- ____ Medical Ethics: The Physician as Gatekeeper
- ____ Medical Evaluation for Disability Claims
- ____ Multiple Sclerosis: Update on Diagnosis and Treatment
- ____ Nephrology for the Eighties
- ____ Neurological Examination: Methods and Interpretation
- ____ Pulmonary Disease in the Elderly
- ____ Sexual Myths and Marital Counseling

- -

Name ____
(please print) (first) (initial) (last)

Street ____

City, State ____________________ Zip ____________ Phone ____________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ____________ Other ____________

Tuition Schedule for Courses:

MSMS members: $7 per credit hour, or $21 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $14 per credit hour, or $42 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ____________ Wednesday lunch ____________ Thursday lunch ____________
- Indicate total number of half-day courses:

____ x $21 (members) $ ____________
____ x $10 (retired) $ ____________
____ x $42 (non-members) $ ____________
____ x $ 5 (residents) $ ____________

- Please enroll me in the MSMS/PSG seminar, being held from 7-9 p.m. Tuesday, Nov. 12, "A Physician's Guide to Professional Investment Management" (Physicians' guests are free.)

____ x ($21 fee) $ ____________

TOTAL $ ____________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

Photo highlights of the 1985 AMA House of Delegates

John Coury, MD, is AMA president-elect

AMPAC Chairman Thomas R. Berglund, MD, Portage, calls for physicians' grassroots political involvement as he addresses the AMA Annual Meeting June 16-20 in Chicago.

Immediately upon his election as AMA president-elect, John J. Coury, MD, Port Huron, thanked the delegates for "this honor, the highest of my life." "In these tense times," he continued, "may we, as physicians, all be healers."

Donald K. Crandall, MD, Muske
chaired an AMA reference com
tee at the annual meeting. MS
President Richard J. McMurray,
Flint, also chaired a reference
committee.

At the annual meeting of the AMA Hospital Medical Staff Section preceding the AMA meeting, Michigan delegates Peter A. Duhamel, MD, Rochester, left, and Gary Maynard, MD, Kalamazoo, followed the deliberations. Doctor Duhamel is chairman of the Michigan MSMS Hospital Medical Staff Section, and Doctor Maynard is past Michigan chairman.

Doctor McMurray, standing, presided at breakfast caucuses of the Michigan delegation.

Prior to his election as AMA president-elect, Doctor Coury, left, led AMA Board meetings. He served as AMA Board Chairman since 1981. AMA Executive Vice President James L. Sammons, MD, is at right.

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PHYSICIANS IN THE NEWS

By Sheri Greenhoe
Managing Editor

Anderson

Bielawski

Blondy

O'Neil

Sphire

Swanson

David M. Reifler, MD, Grand Rapids, authored an article that appeared in the February issue of the *Archives of Ophthalmology.* The article presented a new technique in the diagnosis of metastatic cancer. **Don Liu, MD, Sudha Kini, MD** and **Ray Littleton, MD,** all of Detroit, cooperated on the article. ... Taking the office of president in October of the American Association of Automotive Medicine is **Marshall J. Blondy, MD,** Livonia. He is the first pediatrician chosen to head AAAM, which promotes car passenger safety and includes physicians, nurses, engineers, automobile manufacturers and insurance companies. ... **Sidney Goldstein, MD,** Detroit, has been elected to serve as College Governor for the State of Michigan by the American College of Cardiology's Board of Trustees. College Governors are responsible for reviewing all applications for membership to the college within their areas and for making recommendations to the College's Credential Committee. ... **Raymond D. Sphire, MD,** Detroit, has been elected to a fifth consecutive term as chief of staff of the Detroit-Macomb Hospital. ... **Stephen J. Mathes, MD,** San Francisco, is the new head of plastic and reconstructive surgery at the University of Michigan Medical School. ... **Shirley Jenkins Phelps, MD,** Ann Arbor, has been elected director-at-large of the American Lung Association. She will serve on the national Board of Directors until May 1987. ... **Ronald L. Krome, MD,** Southfield, is the new president of the American Board of Emergency Medicine. He has been a member of the board since its inception. ... **James O'Neill, MD,** Clarkston, was presented the Special Award of Super Person at the Independence Township Sixth Annual Committee Awards Ceremony. Doctor O'Neill was honored for his donation of physicals, his care of area priests and his interest in local politics. ... Elected to his second three year term on the Board of Trustees of the American Heart Association of Michigan is **John Bielawski, MD,** Dearborn. ... **Alfred B. Swanson, MD,** Grand Rapids, is the recipient of the Distinguished Service and Health Care Award from the Hospital Council of West Michigan. Also he presented "The Long-term Results in Implant Arthroplasty of the Forefoot" at the 97th Annual Meeting of the American Orthopaedic Association held recently in Palm Beach. ... The American Academy of Thermology has released the results of its accrediation examinations in thermography. Among those qualifying for board certification is **Donald Lawrence Newman, MD,** Southfield. The tests are the first such examinations in the field of thermography. ... **W. E. Maldonado, MD,** Lansing, recently was honored by the American College of Physicians Executives for having attained the highest level of achievement in both the practice of medicine and the management of health care organizations. ... **Walter L. Anderson, MD,** Grosse Pointe Woods, is retiring after 50 years of service at Harper-Grace Hospitals. During his 50 years, Doctor Anderson was assistant clinical instructor and clinical instructor at Harper Hospital. He was also clinical associate professor and clinical professor at Wayne State University. ... Newly elected president of the Southeastern Michigan Surgical Society is **Elie D. Aboulafia, MD,** Farmington. Named as president-elect is **Allen Silbergleit, MD,** Pontiac; secretary is **Alexa Canday, MD,** Detroit and **Janusz Subszynski, MD,** Harper Woods. ... **Robert D. Warnke, MD,** Plainwell, was admitted to Fellowship in the American College of Physician Executives.☐

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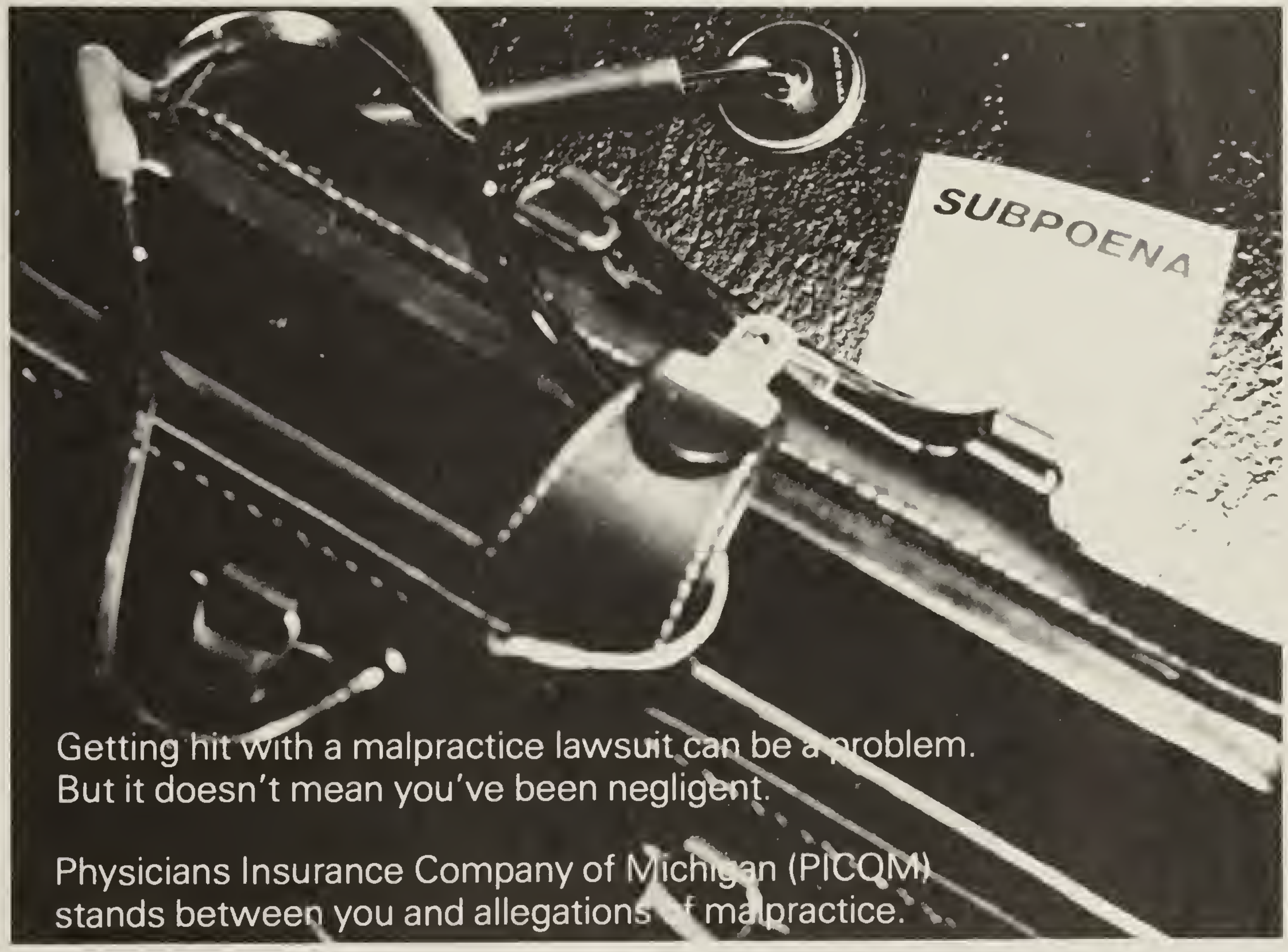
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Patients sought for diabetic retinopathy study

The study of a new investigational drug which may prove effective in preventing or retarding vision loss due to diabetes is under way in Henry Ford Hospital's Department of Ophthalmology. There currently is no approved drug available which has been proven effective in the prevention or progression of diabetic retinopathy. It is one of the major causes of blindness in the US affecting more than 90 percent of long-term (20 years or more) diabetics.

Patient volunteers who have diabetes are being sought for the study, with all exams (including two complete physicals, eye exams, EKGs and blood tests) and lab work to be paid for by the study grant. Patients may be either insulin-dependent or not. They will be involved in either a one or two year study and will be required to come to the hospital's Ophthalmology Clinic for at least 10 visits during that time period.

The drug to be used is an aldose reductase inhibitor, which works to prevent the aldose reductase enzyme from turning the diabetics' elevated level of glucose into sugar alcohol (sorbitol), which has been found to severely damage cells in the lenses of eyes of laboratory animals.

For further information about the study call Anne Morgan, Henry Ford Hospital's Department of Ophthalmology (313)876-7283.

Diabetes research, resources

The Diabetes Center Unit (DCU) of the Michigan Diabetes Research and Training Center (MDRTC) and Department of Internal Medicine at University Hospitals in Ann Arbor provides care for adults in diabetes. The ten-bed unit offers state-of-the-art treatment, extensive patient education classes and materials, possible participation in research projects, and follow-up care as desired in an outpatient clinic. The DCU gives particular attention to the patient who desires an improved control of insulin pumps for certain patients with Type I diabetes. Presently 33 patients are enrolled in the study and are experiencing improved diabetes control. Additional patients are being enrolled. Patient need not be involved in a research project to receive insulin pump therapy if there is an indication for its use. Another research project is studying the use of Sorbinil in the treatment of diabetic peripheral neuropathy.

The Diabetes Center Unit and the Michigan DRTC offer additional resources for the care of diabetes. A new series of detailed diabetes instructional outlines has been developed and is available for use by diabetes educators. Also available is a series of fifteen patient education booklets which deal with such topics as diabetes and pregnancy, laser treatment for diabetic retinopathy, and learning to live with diabetes. A "Life with Diabetes" brochure may be obtained from Media Library, University of Michigan Medical Center, R4440 Kresge I, Box 56, Ann Arbor, MI 48109. It lists all of the instructional materials which may be purchased.

General inquiries or questions concerning admissions, outpatient appointments and research projects may be directed to John C. Floyd, Jr., MD, Director, Diabetes Center Unit (313)764-5218.

New symptoms in polio survivors

Ten to fifteen thousand current Michigan residents once had paralytic poliomyelitis. Most have maintained a stable functional level for the past three to four decades. An upcoming conference on the late effects of polio is a response to the large numbers of polio survivors that are experiencing new losses in their independence, work productivity and general level of functioning. These losses result from new and unexpected symptoms—unaccustomed fatigue, muscle weakness, muscle and joint pain, respiratory difficulties and cold intolerance. Information on the causes and appropriate treatment of such symptoms has been lacking.

Researchers such as Frederick Maynard, MD, Director of the Post Polio Clinic, University of Michigan, and Richard Bruno, PhD, Associate Professor of Physiology, Columbia University, New York, have adopted the term post-polio sequelae as a general descriptor of the new symptoms. It is estimated that post-polio sequelae affect up to 20-25 percent of the survivors of paralytic polio. The researchers believe that the cause of the neuromuscular changes in post-polio sequelae may be an increased attrition rate for healthy motor neurons in the anterior horn cells that have been responsible for a greater than normal percentage of muscle function for several decades. Fortunately, many patients present with post-polio sequelae that are readily diagnosed and treated, e.g. carpal tunnel syndrome and genu recurvatum. In others, the new symptoms will not have a known etiology and treatment at this point is symptomatic.

The October 21 Conference on the late effects of polio (see Category I listing on page 512) will present clinical research studies of causes, diagnosis, and medical management from pioneers in post-polio sequelae research.

Patients needed for pregnancy study

Pregnant women who are at high risk for pre-term births can participate in a research project aimed at developing methods to reduce the risk of delivering a premature baby.

The project is the result of a Michigan Department of Public Health project grant to William

Beaumont Hospital. The grant, entitled "Prevention of Pre-term Birth in a Community Hospital," is directed by Robert P. Lorenz, MD, vice-chief of obstetrics and director of maternal-fetal medicine.

Patients who are enrolled in this project will receive the usual obstetric care, inpatient care and delivery by her physician. In addition, they will receive special education in detecting and preventing signs of possible early labor. Surveillance and follow-up in a private office setting by the investigators also will be conducted at no charge.

Physicians may contact Beaumont's Division of Maternal/Fetal Medicine Department at (313)288-1968 for further information.

Alternative to spinal surgery

The First Symposium on Alternatives on Spinal Surgery recently highlighted chemonucleolysis as the procedure of choice for least-invasive clinical treatment of back problems. The meeting took place in Paris in July. Symposium co-chairman John McCulloch, MD, associate professor of orthopedic surgery, Northeastern Ohio Universities College of Medicine said that, "There is clear evidence that, due to the shortened length of hospital stay and the decreased utilization of hospital facilities, hospital costs of least-invasive procedures such as in-patient chymopapain and microsurgery are about 55 percent of standard laminectomy costs."

More than 200,000 Americans suffering from severe back pain conditions each year turn to surgery in the hope of curing, or lessening, the pain. Symposium speakers said it is possible for particular conditions such as disc herniations to be treated with chemonucleolysis as an alternative to surgery. This procedure consists of an injection of chymopapain directly into the disc, which acts by dissolving the herniated portion of the disc without surgery.

The consensus of the meeting faculty was that therapeutically, chemonucleolysis is as effective and safe as spinal surgery. In comparing a retrospectively reviewed group of surgically treated versus chemonucleloysis treated patients, Robert Charles Mulholland, MD, consulting orthopedic surgeon at Nottingham Hospital, Nottingham, UK, found that, "The successfully treated chymopapain-treated group was as good as, and in some respects better than the surgically successful group." Since 1978 his group has treated over 300 patients with a six percent success rate.

Alain Deburge, MD, symposium co-chairman, and professor in the Department of Orthopedics of the Hospital Beaujon, Paris said that, "The clinical aspects of failures (of chemonucleolysis) are persistant low back pain and persistant or recurrent radicular pain." He described a study of 250 patients reviewed with a six month follow-up. He found that the rate of secondary operations (following failure with chemonucleolysis) was 15 percent. "The lateral recess syndrome was the most common cause (of failure); it was encountered in 16 of 38 patients. In contrast, a sequestrated disc was found in only four patients. Failure of the enzyme to 'digest' the protruded fragment was the cause of persisting sciatica in eleven patients. No abnormality or recurrence at another level was found in the remaining patients." He concluded that, "The success rate was 70 percent with the best results obtained when a sequestrated disc or lateral stenosis was disclosed."

Practice site selection service

The AMA has announced a new service that will be of interest to physicians interested in developing or modifying their medical practice. The AMA Market Area Profile (MAP) Service is designed to assist physicians in establishing and maintaining a successful medical practice by providing them with detailed demographic and health resource data on an existing or planned practice site.

The MAP Service offers physicians individualized, computer-generated data profiles on any area in the US. Each Market Area Profile consists of six data reports:

Area Profile Report—1980 census data (e.g. population, age, sex, housing, occupation, income) for the area that the physician has selected; *State Area Profile Report*—1980 census data for the state in which the physician-selected area is located, provided for comparison purposes; *Demographic Trends Report*—1980, current year, and five year projected population and demographic data (e.g. population, age, sex household size); *State Demographic Trends Report*—A trends report for the state in which the selected area is located, provided for comparison purposes; *Physician Report*—Statistical information on the number of physicians in the area, by medical specialty, age, and major professional activity ; and *Hospital Report*—Detailed information on hospitals in the selected area number of beds, admissions, utilization and census figures, facilities and services, and medical staff profile. If there are more than four hospitals in the selected area, a summary listing of the hospitals is provided instead.

The cost of the Market Area Profile Service ranges from $95 to $195, with substantial discounts for AMA members, medical students and residents. Along with the six profile reports, physicians receive a user's manual that provides data source information and offers useful advice on how to interpret and apply the data to a practice situation.

For further information, and to receive the MAP Registration Package, contact the AMA Market Area Profile Service, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610 (312) 645-4719.☐

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By Deborah Zannoth

HMO growth and physician participation

Since the National Health Maintenance Organization Act was implemented in 1973 the growth of HMOs has been tremendous. In Michigan, the expansion over the last ten years has followed national trends. In 1975 there were three HMOs serving 130,000 people. Today Michigan has 20 licensed HMOs which represent more than one million Michigan residents.

With the increase in HMOs the number of physicians involved in these arrangements also has expanded. A recent informal survey of all licensed HMOs in Michigan by the MSMS Department of Medical Economics and Health Care Delivery indicated a total of approximately 6,700 physicians involved in HMOs at independent physician offices and 136 institutional sites. This figure indicates that almost half of the practicing physicians in Michigan have an arrangement with a Michigan HMO.

A recent report conducted by Louis Harris and Associates on the attitudes of consumers, employers and physicians indicate that many of today's consumers are willing to be involved in emerging non-traditional delivery systems. This report also indicated that 57 percent of the prepaid physicians have been in practice ten years or more and that 78 percent are board certified.

It now seems apparent that HMOs in Michigan will continue to grow along with the other health care options, such as Preferred Provider Organization, now competing in the state for the consumer health care dollar.☐

Ms. Zannoth is MSMS assistant for medical economics and health care delivery.

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Amway Grand Plaza Hotel
Grand Rapids, Michigan

November 7, 1985
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Robert Baker, M.D.
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November 8, 1985
"Management of Cardiovascular Disease: New Frontiers"
Harold Holbrook, M.D.
Fred Morady, M.D.
Norman Schumway, M.D.
Luis Tomatis, M.D.

Contact: Patricia Marks
Symposium Coordinator
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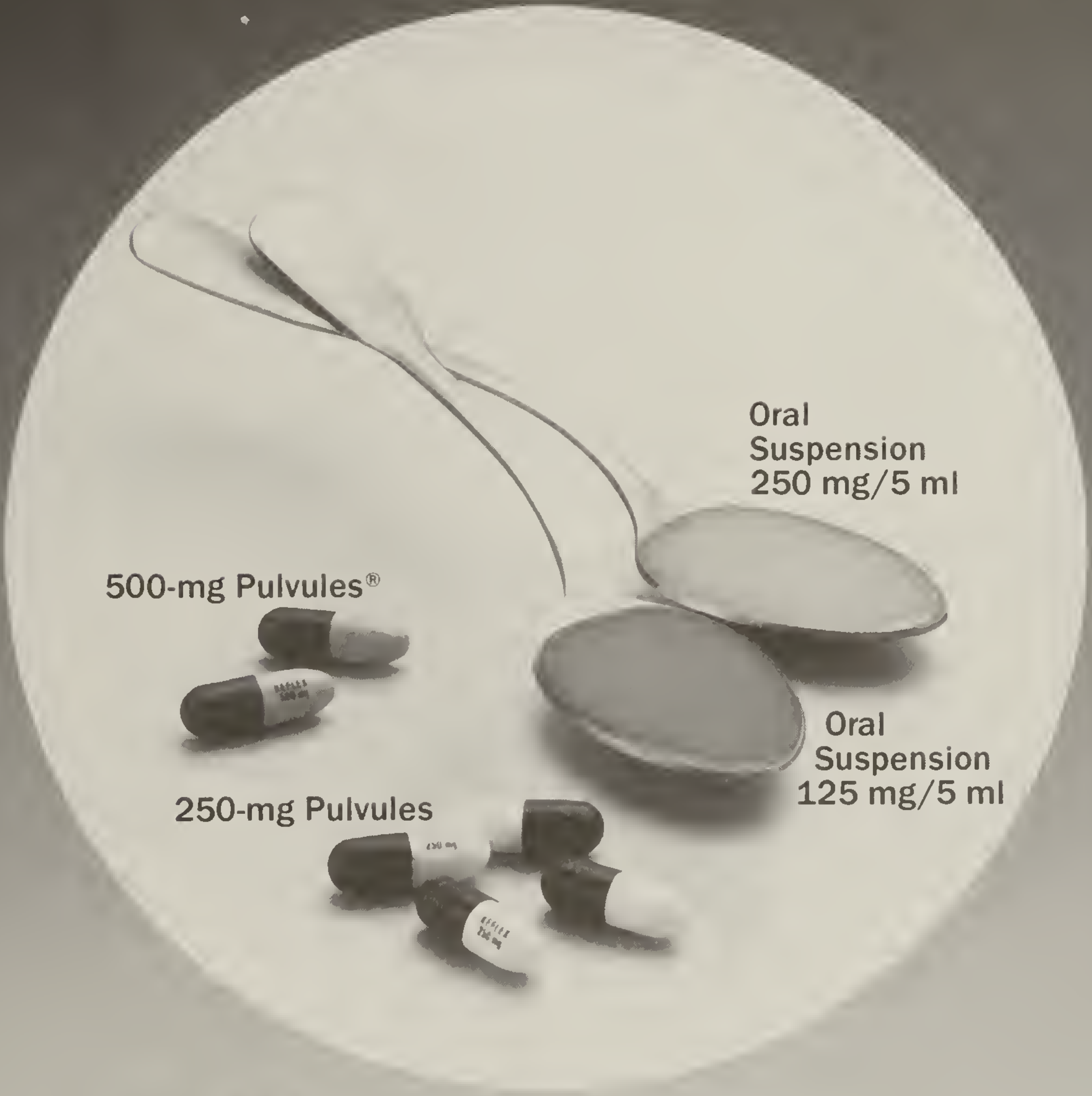
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By Katharine S. Brown

Why real estate?

In one form or another, most adults are investors in real estate. For either renters or owners, providing the roof over their heads makes real estate the largest investment for most households.

For many, personal involvement with real estate begins and ends with their homes. Renters view the cost of a house or apartment as a monthly expense with few financial benefits. Owners, on the other hand, experience real estate on another level. Beyond meeting basic needs, it offers significant investment advantages.

This article is intended to sketch a broad view of investment real estate, its advantages and its place within a portfolio.

When real estate is owned as an investment, for reasons beyond simple housing, the advantages expand. Properly structured investment real estate produce the following benefits:

- Cash distributions
- Tax benefits
- Equity buildup
- Increased value and appreciation

Cash distributions

Personal residential real estate is not intended to produce cash income to the owner, and certainly not to the renter. However, an income return is of great importance in investment real estate. In many instances, it may be the principal reason for making the investment. The income produced by an individual property is affected by a variety of factors, such as location, property use, operating expenses, financing costs and management.

In general, most investment real estate is intended to factor

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Ms. Brown is an investment advisor with Prescott, Ball and Turben, Inc., East Lansing.

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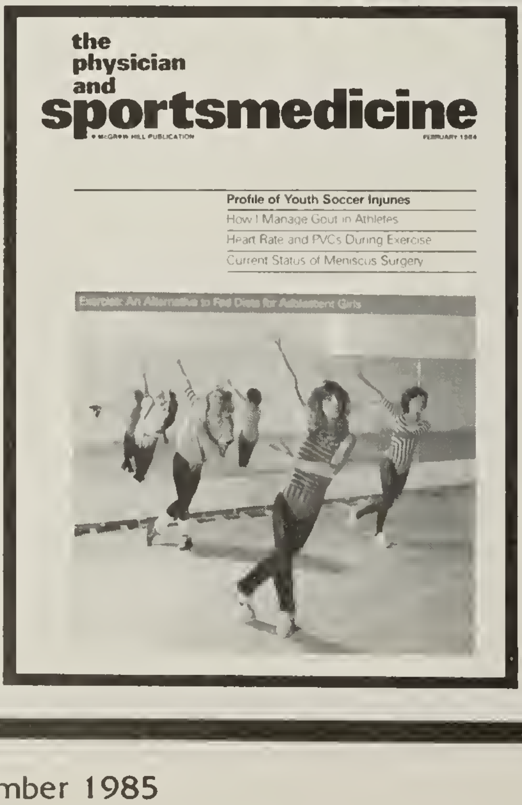
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in these variables and produce cash distributions—distributions that should increase over time. Known and anticipated cash distributions, from investment real estate are central to its value. Buyer and seller both place high value on present and future cash flow.

It is common practice to compute the fair market value of income-producing real estate as a ratio of anticipated income to price, in a way not dissimilar to the price/earnings ratio familiar to common stock investors.

Tax benefits

Real estate offers several important tax benefits. Most homeowners are accustomed to deducting certain costs in association with a residence, i.e., the interest on the mortgage and property taxes. Significant as these are, investment real estate adds further deductions.

- **Depreciation** allows for the gradual deducation of the cost of a capital asset over its cost recovery period, usually 18 years for real estate.
- In the ordinary course of **operating** investment real estate, costs like maintenance and insurance are incurred, which may be deducted against rental income from the property.
- As either other capital investments, real estate is generally eligible for the lower **capital gains** tax rates, if held for more than six months.
- At some time during the life cycle of a real estate investment, it is not uncommon for the higher rental income to justify **refinancing.** The original loan is replaced by a new, often larger, loan. If no concurrent sale occurs, the new cash available from the larger loan may be distributed without being subject to taxation.

Equity-building loan reduction

Increases in the investor's equity result from principal payments made on loan against the property. This mortgage paydown is considered a significant benefit because it allows property owners to pay their loans with rent dollar supplied by the tenant.

Appreciation

Such variables as property improvements, inflation and changing market conditions justify increased rents. As a higher rent level is maintained, a higher selling price may be asked by the owner.

Most of the benefits associated with real estate have been available to investors for years. Certain unique tax advantages are more recent additions. It was not, however, until the advent of limited partnerships and Real Estate Investment Trusts that the average investor began to participate in these benefits. These two vehicles opened the door to the advantages of real estate without the necessity of becoming involved in day-to-day management responsibilities. In this respect, they mirror the convenience offered by traditional stock and bond investments. ☐

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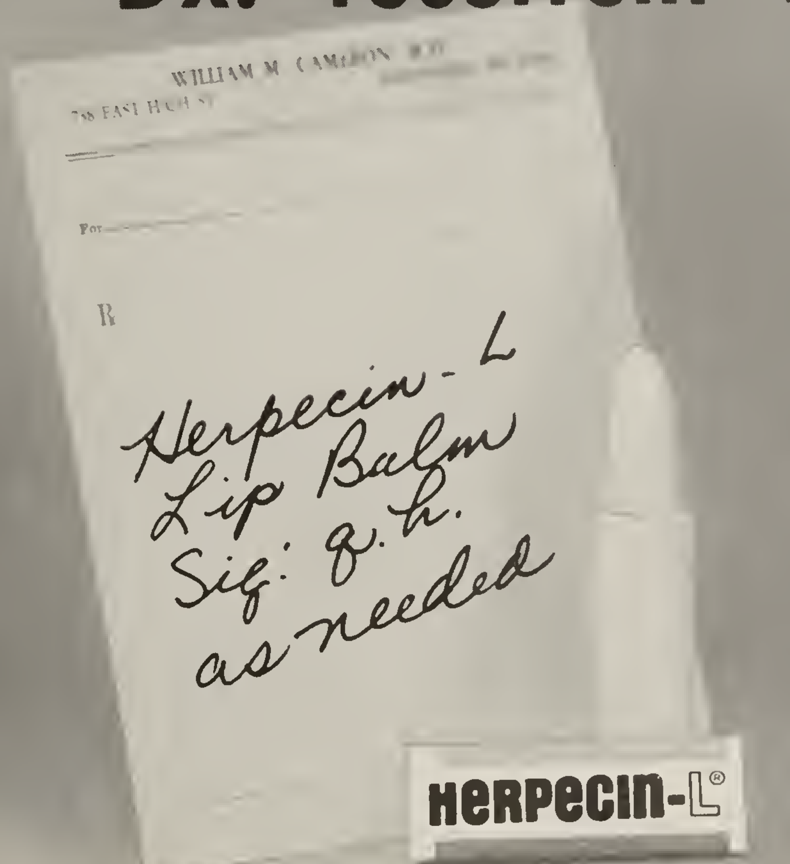

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: September 18, Primary Care Medicine. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6.5 hours of Category I Credit.

Date: September 19-20, Mechanical Ventilatory Support and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: September 20, Reflections on Suicide and Suicide Prevention Location: Sheraton Inn, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Western Michigan Psychological Association **Contact:** Nancy Petty (616)966-5600, ext.3594 **Approved for:** 6 hours of Category I Credit.

Date: September 20-21, Interventional Radiology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 16 hours of Category I Credit.

Date: September 23-24, Antibody, Special Coagulation and Platelet Techniques Workshop. Location: Kellogg Center for Continuing Education, MSU. **Sponsor:** Colleges of Human Medicine-Osteopathic Medicine, Michigan State University. **Contact:** Joan Martin Alam (517) 353-7822. **Approved for:** 19 hours of Category I Credit for MDs and DOs.

Date: September 25, Renal Problems for the Practicing Physician. Location: Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education & Michigan Nephrology Center. **Contact:** Arthur L. Riley, Michigan Nephrology Center, 1717 Shaffer St., Suite 210, Kalamazoo, (616)349-6759 Ext. 7140 **Approved for:** 7 hours of Category I Credit.

Date: September 25-27, Practical, Clinical and Laboratory Aspects of Blood Coagulation. Location: Kellogg Center, MSU. **Sponsor:** Colleges of Human Medicine-Osteopathic Medicine, Michigan State University. **Contact:** Joan Martin Alam (517)353-7822. **Approved for:** 19 hours of Category I Credit for MDs and DOs.

Date: September 26,(plus five once-a-week sessions, October 3,10,17,24,) Chemical Dependency. Location: Okemos Community Education, Okemos. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn, 48126 (313)271-6502 **Approved for:** 3 hours of Category I Credit.

Date: September 26-28, Implant Surgery for the Hand and Upper Extremity. Location: Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Col-

Continued on page 510

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Do you know where these members are?

The MSMS Department of Membership, Operations and Meeting Planning has no information on the whereabouts or membership status of eight physician members. If you have information about one of these doctors, please share it with Peg Berry at MSMS headquarters, 120 W. Saginaw, East Lansing 48823 (517) 337- 1351.

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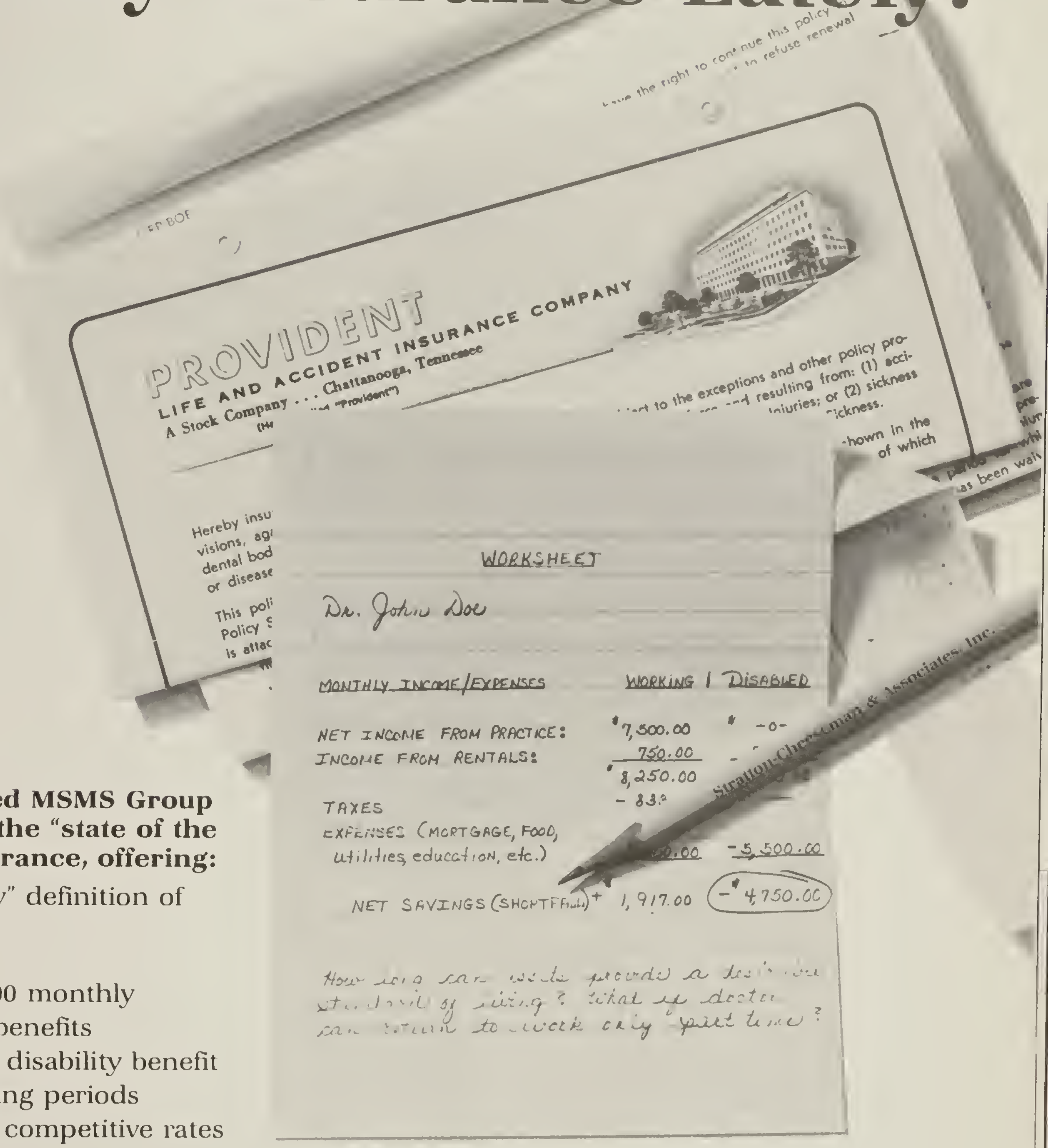
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orado 80014 (303)755-4588. **Approved for:** 18 hours of Category I Credit.

Date: September 27-29, Eighth Annual Course in Diagnostic Ultrasound. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan. **Cost:** Approx. $295. **Contact:** Jolene Glaspie, The Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313)763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 29-October 1, Growing Pains. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** Michigan Alcohol and Addiction Association, Michigan Association for Marriage and Family Therapy. **Contact:** Michigan Alcohol and Addiction, 21711 W. Ten Mile Rd. Suite 105, Southfield 48075. **Approved for:** 10 hours of Category I Credit.

Date: September 29-October 1, Tutorial on Myofascial Release Technique. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Human Medicine and Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714 **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: September 30-October 4, Family Practice Review. Location: McGregor Memorial Conference Center, Detroit. **Sponsors:** Wayne State University School of Medicine, Department of Family Medicine. **Contact:** Wayne State University School of Medicine, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180 **Approved for:** 35 hours of Category I Credit.

Date: October 2, (plus five once-a-week sessions, October 9,16,23,30,) Chemical Dependency. Location: Detroit. **Sponsor: Fairlane Health Services Corp. Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-6502. **Approved for:** 3 hours of Category I Credit.

Date: October 2, Coronary Artery Disease III. Location: St. John Hospital, Detroit. **Sponsor: St.John Hospital.Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 4, 6th Annual Trauma Day. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Bronson Methodist Hospital and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar Bouma (616)383-7576. **Approved for:** 7 hours of Category I Credit.

Date: October 4, Early Revascularization in Acute Myocardial Infarction. Location: Borgess Medical Center Auditorium. **Sponsor:** American Academy of Family Physicians, Kalamazoo Chapter of the Michigan Heart Association and Southwestern Michigan Area Health Education Center. **Contact:** Sharon Nocera (616)383-5940. **Approved for:** 6 hours of Category I Credit.

Date: October 4-5, Lipid Profiles of Age-Group Athletes. Location: Kellogg Center, East Lansing. **Sponsor:** MSU College of Human Medicine, MSU Lifelong Education Program, MSU College of Education, Big Ten Cooperative Intercollegiate Committee. **Contact:** Mary Edna Helfer (517)353-8856. **Approved for:** 13 hours of Category I Credit.

Date: October 4-5, Advanced Trauma Life Support. Location: Borgess Medical Center, Kalamazoo. **Sponsor:** Borgess Inflight Medical Service. **Contact:** Borgess inflight Medical Service, 1521 Gull Rd., Kalamazoo 49001 (616)383-7145 **Approved for:** 16 hours of Category I Credit.

Date: October 4-6, Technological Advances and the Anesthesiologist. Location: Amway Grand Plaza, Grand Rapids. **Sponsors:** Michigan Society of Anesthesiologists and University of Michigan Department of Anesthesia. **Contact:** Caroline Rich, MSMS headquarters (517)337-1351 **Approved for:** 7 hours of Category I Credit.

Date: October 5-6, The Geriatrics Challenge/The Medical Response. Location: Holiday Inn, Petoskey. **Sponsor:** Burns Clinic. **Contact:** Kay Kelly, (616)348-

Continued on page 510

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4500. **Approved for:** 12 hours of Category I Credit.

Date: October 5-6, Medical Mycology and Parasitology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital, Department of Dermatology. **Contact:** Dennis Babel, PhD, 2799 West Grand Blvd., Detroit 48202 (313)876-2159. **Approved for:** 12 hours of Category I Credit.

Date: October 7-11, Tutorial and Workshop in the use of Immunocytochemistry and Electron Microscopy in Tumor Diagnosis. Location: Engineering Society of Detroit. **Sponsor:** Michigan Cancer Foundation. **Contact:** Jose Russo, MD, Michigan Cancer Foundation, 110 East Warren Avenue, Detroit 48201 (313)883-0710. **Approved for:** 44 hours of Category I Credit.

Date: October 8-9, Venous Oximetry. Locaton: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School, Section of General Surgery and Department of Surgery. **Contact:** Betty Phillips, Towsley Center, (313)763-1400. **Approved for:** 6.25 hours of Category I Credit.

Date: October 9, Sexually Transmitted Diseases. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 6 hours of Category I Credit.

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Date: October 10-12, Henry Ford Hospital Medical Association Alumni Reunion. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 20 hours of Category I Credit.

Date: October 11-13, Infectious Diseases "Hands-on Pelvic Workshop." Location: Grand Traverse Resort. **Sponsor:** MCAAP Committee on Adolescence and OMNI Corporation. **Contact:** Natalia M. Tanner, MD, 4727 St. Antoine, Hudsell Building, Suite 303, Detroit 48201 (313)831-1300. **Approved for:** 8 hours of Category I Credit.

Date: October 11-13, An Affordable Prescription: Knowledge, Comradery, and Relaxation. Location: Grand Traverse Resort. **Sponsor:** American Academy of Pediatrics. **Contact:** Mr. P. Miles Tiernan, 32245 Hearthstone, Farmington Hills 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 17-18, The Ins and Outs of Critical Care: Fluids, Nutrition and Renal Management. Location: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School Departments of Postgraduate Medicine, Health Professions Education and Surgery and Internal Medicine. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 13.25 hours of Category I Credit.

Date: October 18-19, A Practical Approach to Arthritis for Physicians. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Bronson Methodist Hospital. **Contact:** Chris Pearson, Southwestern Michigan Area Health Ed. Center, 1521 Gull Rd., Kalamazoo (616)383-6360. **Approved for:** 6 hours of Category I Credit.

Date: October 19, Common Problems with Coronary Artery Disease. Location: Somerset Inn, Troy. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076 (313)557-9500. **Approved for:** 7 hours of Category I Credit.

Date: October 21, A Conference on the Late Effects of Polio. Location: Sheraton Inn, Lansing. **Sponsors:** Michigan Department of Public Health, Coalition on the Late Effects of Polio, Michigan Hospital Association and others. **Contact:** Norman Hayner, MD, Bureau of Laboratory and Epidemiology Services, MDPH, PO Box 30035, Lansing 48909 (517)373-1396. Approved for: 4 hours of Category I Credit.

Date: October 23, The Second Annual Conference on Alcholism. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo. **Approved for:** 6 hours of Category I Credit.

Date: October 23, Update on GYN-Oncology. Location: St. John Hospital,Detroit. **Sponsor:** St. John Hospital. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 25-27, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School Department of Radiology and Department of Post Graduate Medicine and Health Professions Education. **Contact:** Dove Margenau, Towsley Center-Box 057, The University of Michigan Medical School, Ann Arbor 48109 (313)763-1400 **Approved for:** 14.25 hours of Category I Credit.

Date: October 26, Update on Infectious Diseases. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 4 hours of Category I Credit.

Date: October 28-29, Laser Medicine & Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School and Department of Anesthesiology. **Contact:** Betty Phillips, Towsley Center (313)763-1400. **Approved for:** 17.25 hours of Category I Credit.

Date: November 2, Women: Current Psychoanalytic Views. Location: Hyatt Regency, Dearborn. **Contact:** Michigan Psychoanalytic Clinic 16310 West Twelve Mile Road, Suite 204, Southfield 48075. (313)557-8633. **Approved for:** 6 hours of Category I Credit.

Date: November 6, Colorectal Cancer: Essentials for the Primary Care Physician. Location: Gilmore Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** American Cancer Society; Kalamazoo Community Hospitals Oncology Program; and Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Rd., Kalamazoo 49008 (616)388-7877. **Approved for:** 5.45 hours of Category I Credit.

Date: November 7, Michigan Family Practice Research Day IX. Location: Michigan State University. **Sponsor:** Michigan State Family Practice. **Contact:** Douglas B. McKeag, MD, Chairman, B-100 Clinical Center, MSU, East Lansing 48824. (517)353-0770. **Approved for:** 10 hours of Category I Credit.

Date: November 7-9, ACLS - Advanced Cardiac Life Support. Location: Genvieve U. & Donald S. Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Education Center. **Cost:** $250. **Contact:** Cyndi Kochevar Bouma, Bronson Methodist Hospital, Life Support Office, 252 E.

Continued on page 515

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CARDIZEM
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P < .005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.   2/84

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

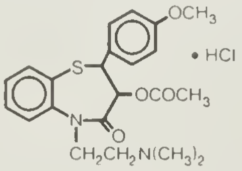
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1 **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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CATEGORY I/Continued

ovell, Kalamazoo 49007 (616)383-7576. **Approved for:** 20 hours of Catego-y I Credit.

Date: November 7-8, Recognition and Management of the Asphyxiated Newborn. Location: Towsley Center, Ann Arbor. **Sponsor:** Department of Pediatrics and Communicable Diseases. **Contact:** Betty Phillips, Towsley Center Box 057, Ann Arbor, MI 48909 (313)763-1400 **Approved for:**14 hours of Category I Credit.

Date: November 12-14, 1985 Annual Scientific Meeting, "From here to eternity." Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 18 hours of Category I Credit.

Date: November 13-14, Advances in Pediatric Hematology/Oncology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 20, A Clinical Day on Alcoholism. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital, CME Committee. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 Category I Credits.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 23-25, Tutorial on Fundamental Principles of Manual Medicine as Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: December 2-6, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: February 12, 1986, Pediatric Neurology. Location: St.John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

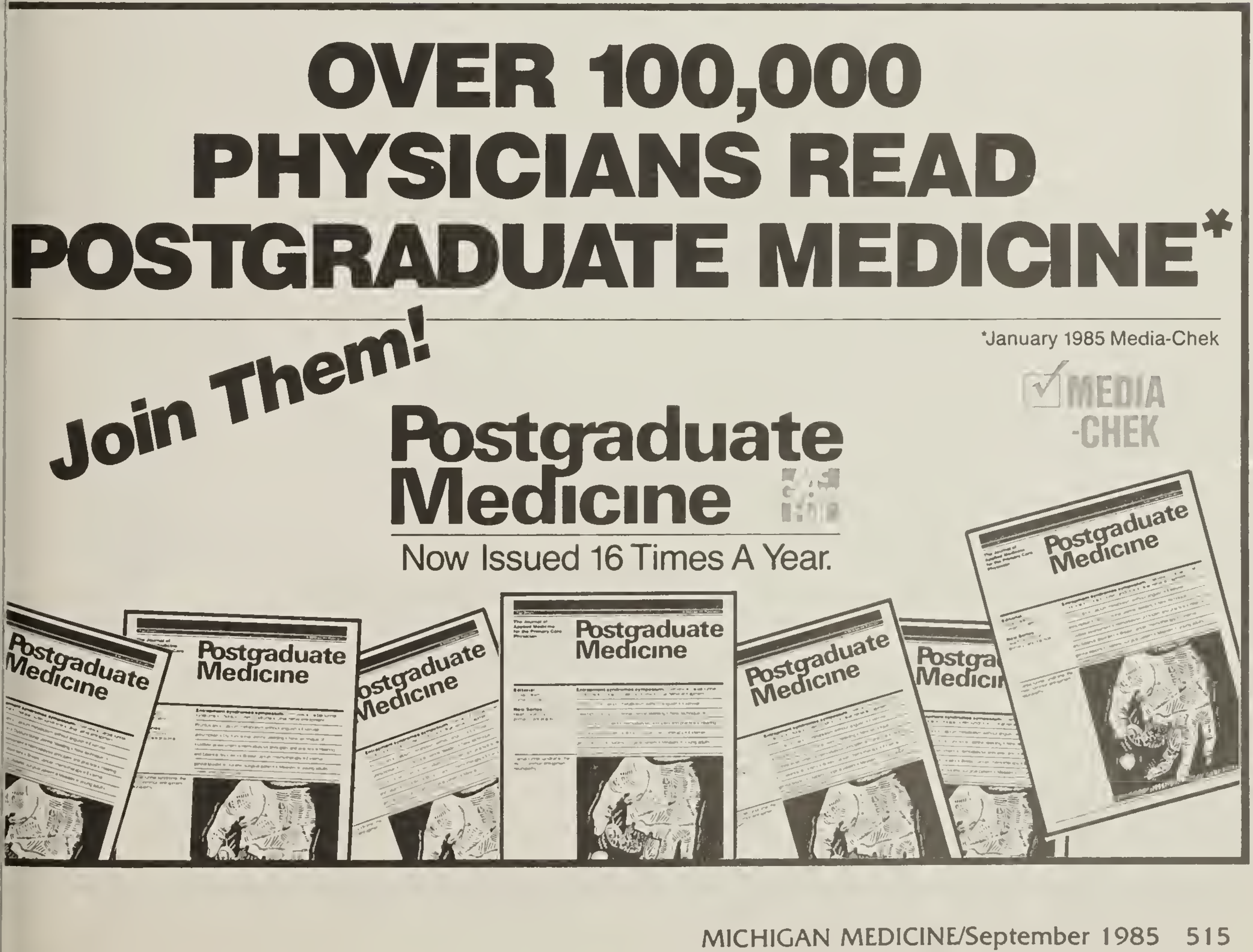
Date: February 26, (plus five once-a-week sessions March 5,12,19,26,) Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp.,One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-6502. **Approved for:** 3 hours of Category I Credit.

Date: March 12, 1986, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: April 7-9, 1986, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School.˙**Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, 1986, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 16, 1986, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.



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DEATHS

William K. Anderson, MD
Saginaw
Doctor Anderson died June 21 at the age of 88. He received his degree in radiology from the University of Michigan. He was a member of the American College of Radiology and was past president of the Saginaw Medical Society.

David Feld, MD
Southfield
Doctor Feld, 70, died July 4. He graduated from the University of Michigan Medical School. Doctor Feld practiced medicine in Detroit for 40 years. He was a former adjunct professor of medicine at Wayne State University and former chief of obstetrics and gynecology at Detroit's Sinai Hospital.

Joseph F. Guyon, MD
Wyandotte
Doctor Guyon died June 30 at the age of 68. He had been a doctor of physical medicine and rehabilitation at Wyandotte General from 1966 until retiring in 1982. Doctor Guyon attended Marquette University Medical School in Milwaukee, interned at St. Joseph Hospital in Flint and maintained a family practice in Flint.

William A. Maynard, MD
Sanford
Doctor Maynard, 80, died July 10. He graduated from the Northwestern School of Medicine in Chicago. Doctor Maynard was recently honored for 50 years of medical practice by MSMS and the American Medical Association.

A. Allen Weisberg, MD
Lake Worth, Florida
Doctor Weisberg, 80, died May 22. He graduated from Wayne State University School of Medicine. He had been a general practitioner at Saratoga General Hospital and Detroit's Sinai Hospital.

Warren G. White, MD
Muskegon
Doctor White died July 2 at the age of 67. He had been a practicing physician for 41 years, and was a 1943 graduate of the University of Iowa Medical School. He did his residency in internal medicine at Harper Hospital in Detroit.

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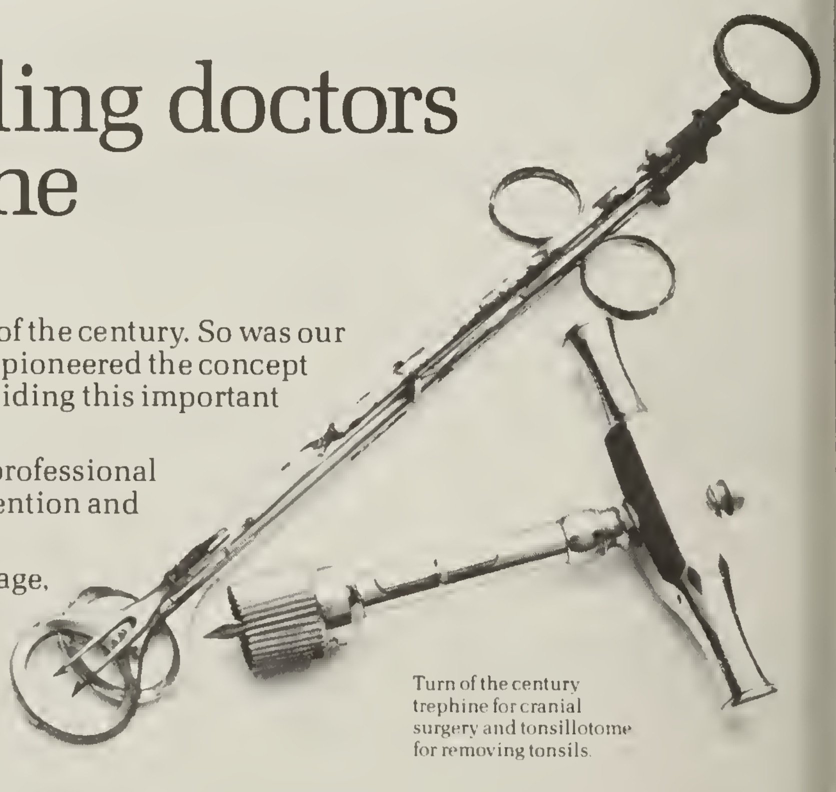

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September 18-19 — AMA 1985 Political Education Conference, Washington, DC, contact: AMA Division of Political Education, 1101 Vermont Avenue, NW, Washington, DC 20005 (202)842-8442.

September 20 — Prescription Drug Diversion Statewide Conference, University of Michigan League Convention and Conference Center, Ann Arbor. Co-sponsored by MSMS and state and local government, professional and community organizations. Contact: Sherry Wellman, MSMS headquarters (517)337-1351.

September 20-22 — Conference on the Well-Being of Physicians, Amway Grand Plaza Hotel, Grand Rapids, contact Katie Brewbaker, MSMS headquarters (517)337-1351.

October 2 — Practice Management Seminar, Sheraton Inn, Flint, contact: Donna Farougi, MSMS headquarters (517)337-1351.

October 9 — Practice Management Seminar, Holiday Inn, Llvonia West, contact: Donna Farougi, MSMS headquarters (517)337-1351.

October 16 —Practice Management Seminar, Troy Hilton Inn, contact: Donna Farougi, MSMS headquarters (517)337-1351.

October 17-19 — AMA National Medical Staff Conference, Sheraton Washington Hotel, Washington, DC, contact: Karen Prupes (312) 645-4418.

October 22 —"Onward to Lansing" Professional Liability Rally, Lansing, contact: Tom White, MSMS headquarters (517)337-1351.

October 24-26 — AMA Third Annual Conference on Stress, Impairment and the Resident, Harrison Conference Center, Lake Bluff, IL, contact: Karen Prupes, AMA, 535 North Dearborn Street, Chicago, IL 60610.

October 30 — Practice Management Seminar, Amway Plaza, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

October 31-November 1 — AMA National Communications Workshop, Westin O'Hare Hotel, Chicago, contact: AMA Divison of Communications, 535 North Dearborn Street, Chicago, Illinois 60610.

November 12-14 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters (517)337-1351.

November 12-13 — Health Policy and Quality of Care for Older Americans, sponsored by the AMA, American Hospital Association, and the American Association of Retired Persons, Radisson Mark Plaza Hotel, Alexandria, Virginia, contact: Pat Clark (312)645-4497.

November 20 — Practice Management Seminar, Stouffer's of Battle Creek, contact: Donna Farougi, MSMS headquarters (517)337-1351.

November 21 — MSMS Leadership Conference, Clarion Hotel & Convention Center (Long's), Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351.

December 4 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: Bruce Ambrose (517)337-1351.

January 22, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: Bruce Ambrose (517)337-1351.

March 19, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: Bruce Ambrose (517)337-1351.

May 2-3, 1986 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: Bruce Ambrose (517)337-1351.

July 17-20, 1986 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: Bruce Ambrose (517)337-1351.

OTHER MEETINGS

September 18 — Michigan Association for Medical Education, University Club, East Lansing, contact: Viola M. Heins (517)337-1351.

October 2 — Oakland County Prescription Drug Abuse Seminar, St. Joseph Mercy Hospital Auditorium, Pontiac. Featured speakers: Mike Wendland, WDIV-TV, Detroit, and John P. Mudri, US Drug Enforcement Administration. Contact: Mary Sue Meyer, Oakland County Medical Society (313)646-4700.

October 6 — Fall Brunch Meeting of Physicians of India Association, Troy Hilton, contact: Doctor Kothari (313)644-1269.

October 8 — Public Health Advisory Council Meeting, Room 1-C, Baker-Olin West Building, MDPH, contact Teri A. Bailey, Executive Assistant to the Director (517)373-3707.

October 24 — Women's Health Day, "Be the Best You Can Be", Dearborn Hyatt Regency, contact: Karen Toupin, Department of Community Health and Health Education, Oakwood Hospital (313)593-7205.

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Watch for details in *Medigram,* or contact Sherry Wellman at MSMS headquarters for more information. 517/337-1351.

By C. Edward Cotton, M

Don't miss the Scientific Meeting!

C. Edward Cotton, MD, Marcellus, 1985 Annual Scientific Meeting chairman, writes for the President's Page this month at the invitation of MSMS President Richard J. McMurray, MD.

It's my privilege to invite each of you to attend the 1985 MSMS Annual Scientific Meeting November 12-14 at the Hyatt Regency Dearborn.

The highest quality continuing medical education courses will be presented at the three-day MSMS session, the results of the planning committee's careful selection and promotion.

Details of all the courses appear in the Special Report at the front of this issue. Please read through that section then fill out the registration form on page 000.

You can earn a total of 18 Category I credits at the three-day session, which presents 55 half-day courses, each awarding three credits.

Physicians who attend all three days will save 40 percent over the new 1985 prices ($7 per credit hour, or $21 per course for MSMS members). Non-members pay $14 per credit hour, while retired physicians pay the reduced rate of $10 per course. Resident physicians pay just $5 per course.

Highlights of this year's program include two series of "alpha-omega" courses. Designed to help the physician study the progress of a disease as it affects patients in early, middle and later years, these series focus on pulmonary disease and diabetes.

The alpha-omega series are spotlighted in this year's Annual Scientific Meeting advertisements, with their themes of "From Here to Eternity," "The Turning Point," and "Heaven Can Wait." You may recognize some movie classics here.

Poster presentations

This year, physicians may meet with colleagues at 21 poster presentations in the Annual Scientific Meeting exhibit hall from 4:30 to 6 p.m. Tuesday and Wednesday, November 12 and 13.

Poster presentations debuted at the 1984 meeting, and proved so successful they have expanded in numbers and space this year.

More of our courses will include patient demonstrations for greater hands-on experience. Among the courses which will provide practical, hands-on kinds of demonstrations are those on gait disorders, scleroderma and pulmonary disease in the elderly.

All but three of our Annual Scientific Meeting courses are approved for prescribed credit by the American Academy of Family Physicians. There is much for the general practitioner, as well as several courses presented by specialty societies for their colleagues.

In the Special Report you will find a list of activities scheduled in conjunction with the Annual Scientific Meeting. This list grow each year as specialty societies, alumni groups and MSMS take the opportunity to reach large numbers of physicians gathered for continuing education.

You will be able to visit the educational and service booths of 70 exhibitors in the large exhibition hall at the Hyatt. This hall also will be the scene of the Annual Scientific Meeting registration area, deli luncheons and coffee breaks. There will be coat check and emergency first aid services nearby.

While you're at the Annual Scientific Meeting, you may attend an evening course presented by the MSMS Physician Service Group, Inc., and the E. F. Hutton Company. Entitled "Mak Your Pension Plan Work as Hard as You Do," this course is a physician's guide to professional investment management through trusts, wills and estates.

MSMS has again selected the excellent facilities of the Hyatt Regency Dearborn for the location of the Annual Scientific Meeting. It is linked by tramway to the huge Fairlane Shopping Center, and is near two world-famous attractions, the Henry Ford Museum and Greenfield Village.

Another feature which has wo physicians' approval year after year is the hotel's free parking and easy access from the Southfield Freeway.

Turn to page 493 now and make your reservations to atten this superb CME offering. By reserving your room early, you ma be eligible for two free nights' stay at the Hyatt and dinner for two in the hotel's excellent Guili and Sons restaurant.

I look forward to seeing you at the Annual Scientific Meeting!☐

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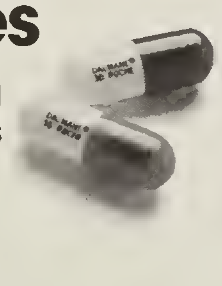

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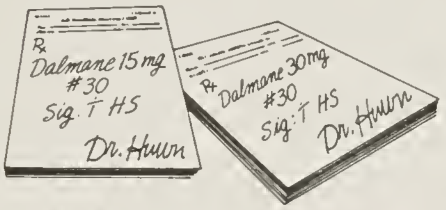

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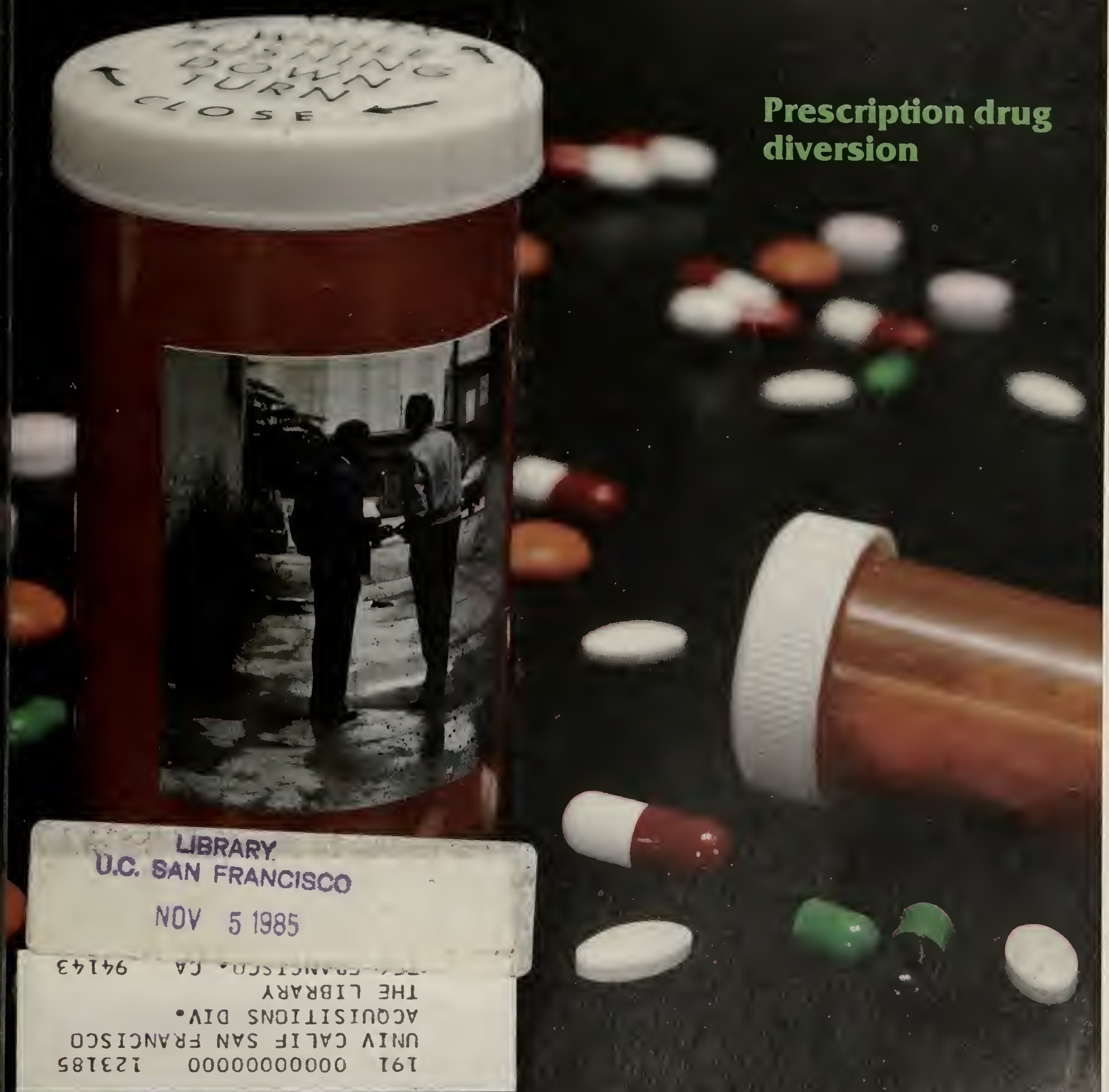
MICHIGAN MEDICINE

October, 1985 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 84, No. 10

Prescription drug diversion



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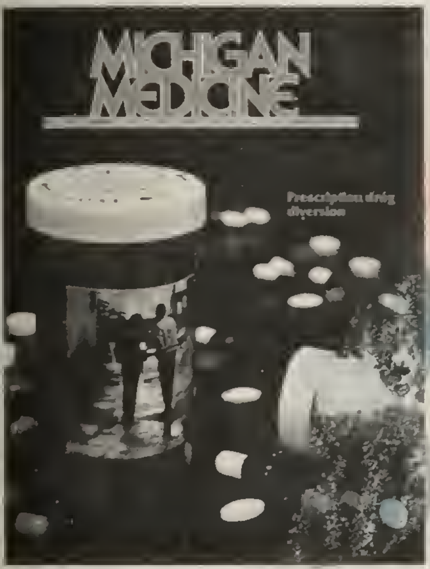
November 12, 13 & 14
Hyatt Regency Dearborn

October 1985, Vol. 84, No. 10

MICHIGAN MEDICINE



About the cover: The diversion of prescription drugs to street use is a back-alley issue in many cases, but not all.

There's a flood of Lawsuits threatening your Health Care is the name of a new brochure aimed at your patients. It explains the current professional liability crisis and outlines MSMS initiatives to ameliorate it. Order your free brochures from the MSMS Department of Communications and Professional Relations *today.*

Special report

526 Prescription drug abuse is a major problem in Michigan. Our state has consistently led the nation in the per capita consumption of legally manufactured stimulant drugs — nine times the national average for methamphetamines. Much of this supply is being diverted in a variety of ways to illegal use. This month's Special Report examines the numbers, and the programs aimed at reducing them. The "patients" likely to dupe a physician are profiled here, and rules and regulations for prescribing controlled substances are summarized: Catherine A. Fish; Herman Fishman; Bruce Medd, MD; Michigan Pharmacists Association; Peter Nowosielski, MD; Joseph Skom, MD and Bonnie Wilford, MS; US Drug Enforcement Administration; Robert E. Weiss, JD.

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In next month's Issue of *Michigan Medicine:* Managing the medical office is an increasingly complex task. Next month's Special Report will provide you with some helpful ideas you can incorporate into your practice.

By Harvey M. Andre, MD

You can't afford to "let George do it"

Doctor Andre

Distribute brochures to your patients and attend the rally!

You all have received in this magazine a brochure for patients describing causes and effects of the professional liability crisis. The brochure, "There's a flood of lawsuits threatening your health care," is available to you, in quantity, at no charge. It points out that in order to protect your patient's access to good care, at reasonable cost, something must be done soon.

Today, concerned physicians are being doubly sure to cover every possible facet of patient care. But, when we are forced to order extra tests to protect ourselves, the cost of medical care rises, and then fingers will be pointed at us for escalating medical care costs. We must be freed from such pressures in order to provide good medical care at reasonable costs to our patients. Isn't that what you want?

We all suffer from frustrations about trying to practice good medicine. There is a constant worry over the threat of malpractice suits, and when you get one you lose sleep, can't concentrate, and your family suffers as well. Furthermore, every suit filed against you, whether meritorious or not, increases your insurance premiums. Can you afford that?

The battle against the professional liability crisis is being carried on by *your* state medical society. We must be united against this malpractice scourge. You can be sure the trial attorneys are united, and in fact plan to be out in force October 22, when thousands of MSMS members will gather in Lansing to demonstrate to legislators the seriousness of the professional liability problem.

So, to spread the word at the grassroots level — to your patients — order more brochures explaining why physicians favor liability reform. Additionally we need *your* presence in Lansing on October 22. There is nothing other than serious illness or death in the family that should keep you from doing your part. The well-being of your patients and your practice is at stake! Don't "let George do it", *you do it!*

Doctor Andre, Grand Rapids, is chairman, MSMS Committee on Publications.

Editor's note: Brochures are available to you at no charge. Contact Joyce Crum at MSMS headquarters.

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Michigan Medicine, the official journal of the Michigan State Medical Society, i dedicated to provide useful information for Michigan physicians about actions o the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editori board of *Michigan Medicine* and advise the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or featur published in the pages of the journal. Th views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserve the right to accept or reject advertising copy. Products and services advertised *Michigan Medicine* are neither endorse nor warrantied by MSMS.

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BCBSM clarifies precertification program

Many of you are aware of the Blue Cross/Blue Shield Precertification Program, especially physicians providing care for many patients employed by the automakers. Now that expected implementation problems have been identified and resolved, it is time to clarify some salient points so that together we may continue to provide patients with quality medical care in a cost-efficient atmosphere.

Within the program, hospital days are "precertified" by the BCBSM staff of 150 registered nurses and 32 physicians. (Emergency admissions are to be approved within 24 hours.) The basic information required at the time of precertification is: name, contract number, social security number, date of birth, provider name, institution, diagnosis, and a very succinct history, including the need for special procedures and/or surgery.

Length of stay days approved are based upon 1983 national averages. Please remember, in many cases, a diagnosis in itself does not guarantee approval of hospital days, but rather the intensity of service to be rendered.

Ninety-five percent of cases are approved by the BCBSM registered nurse receiving the call. Those cases, where the number of days requested exceeds the national average, or the data supplied is insufficient, will be referred to a BCBSM physician for further review. The BCBSM physician may find it necessary to contact the attending physician for clarification of how the provider wishes to proceed.

In some instances, the number of days approved initially may be inadequate. The Precertification Program is very flexible in that additional hospital days may be approved. Simply "recertify" the case by providing information supporting additional hospital stay (complications, new diagnosis, etc.).

While it is ultimately the responsibility of the attending physician to supply all necessary information, he or she may choose to delegate the task of precertification or recertification to a utilization review staff.

While the Precertification Program is new to Michigan physicians, customer interest is increasing. We expect many additional groups to select this program in the future. We are constantly smoothing the rough edges (lengthy "on hold" time during precert/recert calls) so that ultimately the process will be expeditious and efficient. Our purpose is not to assume the responsibility of your patients, but to assist in providing the best medical care, while controlling costs. We are open to your comments and suggestions. Address your remarks to: Raymond Rebandt, MD, Senior Medical Consultant (313)225-7534 or Robert Church, DO, Director, Precertification Program (313)225-7534.

Larry J. Sell, MD
Vice President for
Medical Affairs
Blue Cross Blue
Shield of Michigan.

By Robert E. Weiss, JD

Prescription drug diversion — our problem

An overwhelming number of violent crimes, including breaking and entering, in Flint and Genesee County, are directly related to alcohol and/or drug abuse. It was not surprising to me, Genesee County Prosecuting Attorney, or to area law enforcement agencies, that approximately one-half of all drug-related criminal warrants authorized by my office in 1983 involved prescription drugs. They included: Phenmetrazine (Preludins); Methamphetamines (Desoxyn); Amphetamines; Dilaudid; Valium; Percodan; cough syrups; Demerol; and other depressants and pain killers.

When we stop to consider the legitimate manufacturers of these drugs are currently producing more than 20,000 brand name products under the Controlled Substances Act, we should not be surprised by the potential for abuse. Credit must be given to the Act and to federal officials for the significant decline of legally manufactured drugs being diverted to illicit channels for street use. However, despite their efforts, it is still estimated that *300 million* dosage units are being diverted annually for illegal purposes.

According to the Drug Enforcement Administration (DEA), the diversion of prescription drugs is more pronounced at the retail level than the wholesaler or manufacturer's level. DEA officials estimate that about two percent or 13,000 practicing physicians and pharmacists are involved in some form of illicit practice resulting in diversion of prescription drugs.

How diversion occurs

In its simplest form, diversion is high school students and "speed" freaks getting prescriptions for stimulant drugs from "dated" and "duped" physicians. In a more sophisticated form, it is the man-from-out-of-town who opens up a medical clinic and hires physicians to write "scripts" to divert drugs. In its most professional form, it is "script-mill" physicians and pharmacists who divert drugs to the street while perpetrating multimillion dollar insurance fraud.

The diversion of controlled substances from hospitals is also of major concern to law enforcement officials and the magnitude of the problem likely is much greater than we suspect.

Disproportionate quantities

There is even more to disturb us about this persistent problem. These findings have implications the citizens of Michigan are forced to deal with on a daily basis. For the years 1979 through the first six months of 1984, Michigan led the nation in the per capita consumption of legally manufactured stimulant drugs. During that period Michigan experienced increases in total distribution for Methamphetamine (Desoxyn), Phenmetrazine (Preludin), Methaqualone and Hydromorphone (Dilaudid).

Local medical, pharmaceutical, and Federal officials have determined that the only legitimate use for these stimulant drugs is in the treatment of narcolepsy and hyperkinesis.

According to ARCOS/DADS Quarterly Report for the first quarter of 1983, Michigan received almost nine times the national average of methamphetamines and almost three times more than the number two state, Pennsylvania. As if this were not enough, the two top states for Phenmetrazine distribution were Pennsylvania and Michigan: they received 3.9 and 3.6 times the national average for this drug. Michigan constitutes only four percent of the United States population, yet Michigan received 12,772 grams of methamphetamines during the first quarter of 1983, which was 35 percent of the US distribution of the drug. Are we to assume that Michigan has 35 percent of the narcoleptics and hyperkinetics in the nation?

The problem is further magnified when we take into account the direct retail sales of the cancer drug hydromorphone (Dilaudid). During the past four years in Michigan, the total distribution of hydromorphone increased

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Mr. Weiss is Genesee County Prosecuting Attorney.

396 percent. According to the American Cancer Society, Michigan's projected death rate (181 deaths per 100,000 population) is below the national norm (187 deaths per 100,000 population) for cancer-related deaths. Yet the state received at least nine times as much Dilaudid as did the rest of the United States.

The Drug Abuse Warning Network (DAWN) has produced startling statistics recently published by the American Medical Association's Committee on Prescription Drug Abuse. DAWN statistics consistently show the most often abused drugs are legitimate drugs. The study concluded that more than twice as many drug-related injuries and deaths result from prescription rather than illegal drugs. The Comptroller General of the United States, in his 1982 report to Congress stated, "The abuse of prescription drugs . . . results in more injuries and deaths to Americans than all illegal drugs combined."

Unrealistic quotas

In February, 1984, at the invitation of Rep. Peter W. Rodino, Jr., (D-NJ) Chairman, Committee on the Judiciary of the US House of Representatives, I testified before the House Subcommittee on Crime relative to the prescription drug epidemic. At that proceeding I suggested the Federal Government should reexamine the mechanism by which it determines the kinds and quantities of drugs to be produced. The methods currently used to determine and establish quotas are unrealistic, obsolete, and do nothing more than perpetuate the problem. These methods must be changed if we are to remove the glut of legally manufactured drugs from our streets. Manufacturers must learn to see the problems resulting from their overzealous production.

The pharmaceutical manufacturers have clearly demonstrated their unwillingness to project realistic drug (quota) allocations in proportion to the legitimate medical needs of our citizenry. In the absence of this showing, the burden of responsibility for the disproportionate oversupply rests with the manufacturers. I recommended to the subcommittee that the manufacturers be directed to identify and examine the legitimate medical problems and the demographics of our population.

I proposed the establishment of regional drug quotas. This would force the manufacturers to promulgate an inventory of those illnesses which require medical treatment through licit drugs regulated by the Controlled Substances Act. Through the Office of the US Attorney General, manufacturers could utilize to the fullest the resources of the Disease Control Center in Atlanta and the National Institute of Public Health, whose knowledge of science and technology far exceed that of any individual agency.

I believe the concern expressed by some in the medical community that the imposition of quotas would jeoparize the availability of prescription drugs for those who legitimately need them is unfounded and unsubstantiated. In conjuncton with enforcement, the government must provide funding to strengthen the capabilities of state diversion units. By implementing grant programs, the American Medical Associations's PADS project can operate at a level where it can effectively address the major issues of diversion.

Finding solutions

I applaud the strong support expressed by physicians in the fight against prescription drug abuse in this state. The courageous stand taken by the Board of Medicine and the Michigan Osteopathic Board of Medicine and Surgery is a signal to other concerned state boards, as well as to the public, that we can no longer tolerate abuses of prescription drugs. However, this stand is just the initial step. Much more needs to be done.☐

By Joseph H. Skom, MD and Bonnie B. Wilford, MS

PADS: The Michigan experience

***Case:** Jane Doe filled 397 prescriptions in the last two years of her life. She saw 29 different doctors, received 79 services from the same practitioner. One hundred fourteen of her prescriptions were filled by the same pharmacy and reimbursed by Medicaid. On her death at age 22, her blood contained near-toxic levels of two diazepam products and phenobarbital. Urine tests revealed three tranquilizing agents, cocaine, opiates, barbiturates and other "drug-like" substances.*

Doctor Skom is chairman, AMA Informal Steering Committee on Prescription Drug Abuse. Ms. Wilford is coordinator of that committee, and administrator, AMA Substance Abuse Unit.

Of the 1.5 billion prescriptions dispensed in the United States every year, several hundred million dosage units are diverted to illicit use. Such diversion is, unfortunately, a problem that has been overshadowed by concern over the abuse of heroin, cocaine and other "street" drugs. It is, too often, given less public and official attention than is warranted by its impact on the public health. Yet the harsh realities of recent federal statistics are undeniable: prescription drugs are involved in nearly 60 percent of all drug-related emergency room visits and 70 percent of all drug-related deaths.

Continued on page 528

Organized medicine has taken a leadership role in responding to this problem at the national and state levels. Nationally, the American Medical Association in 1981 convened the Informal Steering Committee on Prescription Drug Abuse as an interdisciplinary coalition for problem analysis and program development. The committee, in turn, has sponsored the design and dissemination of a range of practical programs for state use.

Coordinated approach

In the states, medical associations have taken the lead in urging public-private sector collaboration around these programs, in recognition of the fact that a coordinated approach 1) broadens the base of understanding of the problem and the base of support for actions to resolve it, 2) builds rapport among agency and organization representatives who will jointly execute remedial measures, 3) focuses greater resources on the problem than any single agency or organization could command, and 4) engages a range of perspectives in the formulation of appropriate intervention efforts.

The Michigan State Medical Society, for example, has been a co-sponsor of the AMA's PADS project in the state of Michigan. PADS (Prescription Abuse Data Synthesis) is a data compilation and analysis model developed for the Informal Steering Committee on Prescription Drug Abuse by the AMA, the US Drug Enforcement Administration, and state experts on drug control. The PADS process allows states to develop fast, accurate answers to several key questions:

- Are prescription drugs a significant factor in the drug abuse problem in this state?
- What levels of morbidity and mortality are associated with such abuse?
- Which drugs are being diverted and abused, where, and by whom?
- Which individual practitioners and institutions are the sources through which drugs are being diverted for purposes of abuse?

Significant reductions

Working with the assistance of a technical consultant supplied by AMA, authorities in Michigan and other PADS states have achieved significant reductions in the diversion of controlled drugs, as well as in related drug abuse and criminal activities.

In 1983, for example, just prior to implementation of PADS, Michigan ranked in the top 10 states in purchase of the following controlled drugs: Methamphetamine; Phenmetrazine; Methylphenidate; Amobarbital; Secobarbital; Methaqualone; Codeine; Hydromorphone; Meperidine and Methadone.

In fact, Michigan—with only 4 percent of the US population—was purchasing 36 percent of the nation's legally produced methamphetamine.

By mid-1984, on the other hand, preliminary results of the Michigan PADS project showed significant reductions in consumption of all of these drugs, including a 31.8 percent reduction in purchases of methamphetamine.

The results reflect criminal convictions and licensure actions against physicians, pharmacists, podiatrists, dentists and veterinarians who were identified as deliberately diverting drugs for non-medical purposes, as well as criminal actions against “pro-

Recognizing the manipulative patien

Use of illicit drugs plus misuse of some important prescription medications (particularly those with central nervous system effects) increase the possibility that sooner or later most primary care physicians will be confronted with the problem of identifying and dealing with the drug-seeking patient. Whether encountered in a private practice, a clinic setting, a neighborhood health center, a busy emergency room, a rural area or a large metropolitan hospital, these patients can generally be identified by their use of one or more of the following four manipulative approaches; they:

- Assume physical problems—particularly illnesses having symptoms of severe pain (such as renal colic, toothache or tic douloureux) which are generally treated with narcotic medications;
- Feign psychological problems—complaining of insomnia, fatigue, depression and anxiety when stimulants or depressants rather than analgesics are the medicines desired;
- Use deception—employing theft, forgery or alteration of prescriptions, concealing or pretending to take medications and requesting refills prematurely (often with the excuse that the medicine was "lost" or "stolen") to obtain additional supplies;
- Employ coercive tactics—attempting to elicit sympathy or guilt feelings in the physician, using direct threats of physical or financial harm, bribery or citing influential families or friends to obtain the medications they desire.

In addition, physicians should be alert to certain common mannerisms exhibited by these individuals. (See inset.)

The pressure these individuals can bring to bear on a physician

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Doctor Medd is Assistant Vice President and Director, Professional and Marketing Services, Roche Laboratories, Division of Hoffmann-LaRoche, Inc., New Jersey.

By Bruce H. Medd, MD

can be considerable; however, medical experts have suggested that when encountering such a patient, physicians maintain a strong professional control of the situation and regard the patient as having a serious illness. Referral to a specialized treatment program also may be required in some cases. ☐

Common behavioral characteristics of the drug-seeking patient:

- Present dramatic but vague complaints
- Present subjective complaints without confirming objective signs
- Present a self-diagnosis and request specific medication
- Exhibit no interest in confirming a diagnosis or undertaking other forms of treatment
- Exhibit lack of interest in keeping appointments for referrals or diagnostic tests.

fessional patients" who used fraudulent practices to obtain controlled drugs from unsuspecting practitioners.

Further improvements should be seen as a result of adoption by the Michigan Board of Medicine and Osteopathic Medicine of new rules governing the prescribing of methamphetamine, phenmetrazine and other sympathomimetic amine drugs.

Finally, continued collaboration of the type engendered through the PADS project—while it cannot completely eliminate the problem—should provide a significant degree of protection to the health care professionals and other citizens of Michigan.☐

By Peter F. Nowosielski, MD

Why a three part script?

Michigan in 1983 led the nation in per capita purchases of Methamphetamine (Desoxyn), Phenmetrazine (Preludin), Methylphenidate (Ritalin), Codeine and Hydromorphone (Dilaudid). Michigan was 4th in purchases of Meperidine (Demerol) and 6th with Methaqualone (Quaalude).

Our state's recent amphetamine laws will change part of the picture, as will the government's change of Quaalude to Schedule I category.

But, this does not stop the problem with the other Schedule II abused substances.

Seven states have multiple prescription laws for Schedule II substances. Forty-six percent of all script writing practitioners in the United States are covered by the multiple script rule of New York, California, Illinois, Texas, Rhode Island, Idaho and Hawaii.

Present investigations by the Drug Enforcement Agency in southeast Michigan show that in pharmacies investigated for prescription drug abuse, 50 to 99 percent of the scripts are "bogus paper". Twenty-two were written by non-existant physicians. Contrary to the stories of "bad doctor", most abuse is by "misuse by forgery or falsification" of prescriptions. This is directly amenable to correction by use of the triplicate prescription. The dated, duped, disabled or dishonest physician is not as significant a cause of legitimate drug abuse as the newspapers would lead one to believe.

The new form

The state-supplied triplicate prescription ("Trip Script") will be on specially fabricated and colored paper, less amenable to forgery. It will periodically be changed so as to prevent its duplication by fraudulent means.

The "Trip Script" is divided into three parts, one kept by the prescriber and two given to the patient. These are presented to the pharmacist, who in turn keeps one and weekly sends the hard copy to the proper agency. This copy is fed into the computer. Abnormal patterns in amount of drugs by weight or number, by pharmacy, patient or prescriber are spotted and appropriate investigation can be quickly performed.

A law will be passed making illegal possession or propagation of the format of the script a crime, punishable by law.

At present a closed distribution system designed by the Controlled Substance Act of 1970 (Federal Law) and operated by DEA captures and requires recordation of drugs to the retail outlet level. "Trip Script" is the state's extension from the retail level to the street level.

The "Trip Script" will help DEA to pinpoint those in the community who are most likely to be causing the problem and take the onus off the majority of legitimate practitioners and pharmacists. It is a tool for reversing the ever increasing diversion of legal drugs from legitimate sources. Public disclosure of the patient's identity is prohibited and access to the files will be granted to a limited number of health department and investigatory personnel.

The "Trip Script" does cause a tilt to other narcotics such as those in Schedule III. This could be tomorrow's problem and if it occurs we can work on it tomorrow. Today's problem has been with us for too many yesterdays and must be stopped.☐

Doctor Nowosielski is assistant clinical professor, Department of Family Practice, WSU School of Medicine.

Prepared by the Michigan
Pharmacists Association

PRESCRIPTIONS

The DEA number question

An important question has been raised by a physician which deserves a responsible answer and the cooperation of the medical community.

The question: **"Why are pharmacists calling to verify my prescriptions and asking about my so-called DEA number?"**

The DEA number, previously called the BNDD number, references the federal license number issued by the Drug Enforcement Administration (DEA). Physicians must obtain both a federal and a state DEA license to prescribe a special classification of prescription drugs known as "Controlled Substances." In fact, there are four "schedules" of prescription drugs categorized as Controlled Substances and a Schedule V classifying even certain nonprescription or over-the-counter (TC) medications as Controlled Substances.

In similar fashion, a pharmacist and a pharmacy must also have DEA licenses to purchase and dispense Controlled Substances on the prescription of a prescriber who has a valid DEA license.

"A valid physician's DEA license" ... and therein lies the basis of the question from pharmacists to physicians, but not for the seemingly apparent reasons related to the existence of the physician's DEA license number.

The pharmacy community is experiencing a virtual explosion in the incidences of persons attempting to obtain prescription drugs, most often the Controlled Substances, through the use of stolen and forged prescription blanks and other more exotic schemes involving telephoned prescriptions.

The fact is, that on more occasions than most people may be aware, pharmacists must distinguish between a valid prescription for a valid therapeutic need and an attempt to capitalize on the legitimate distribution system vis-a-vis a forged prescription, either written or verbal.

The DEA number becomes an important component in verifying the validity of a prescription about which the pharmacist may be suspicious.

The DEA number is important for another reason. It is a required element of information on the claim form for a patient covered for pharmacy services under third-party programs such as Blue Cross and Blue Shield.

"This information relative to the original question is provided to enhance inter-professional understanding of the distinct yet related factors impacting the practice of both medicine and pharmacy," Genesee County Pharmaceutical Association President Larry Cappel said. "It underscores the continuing importance for liaison and cooperation between pharmacy and medicine, both at the county and the state levels."☐

By Herman Fishman

Board rules ban amphetamine obesity scripts

Based upon a report of the Drug Enforcement Administration, indicating that Michigan ranks number one in the per capita purchase of methamphetamine and phenmetrazine, the Steering Committee on Prescription Drug Diversion and Abuse, in a July, 1984 report to Governor Blanchard, recommended that the administrative rules of the Michigan Board of Medicine governing the standards of practice regarding amphetamines be amended to prohibit the use of amphetamines in the treatment of weight control.

At public hearings held on the proposed amendments, there was unaminous support to ban the use of amphetamines and other sympathomimetic amines for the treatment of weight control. There also was testimony from members of the professional community, including pediatricians, psychiatrists and neurologists that dextroamphetamine be permitted for the legitimate treatment of narcolepsy and hyperkinesis, including attention deficit disorder. The Board, therefore, modified the proposed amendments to permit dextroamphetamine to be used under the provisions of the rule.

The Michigan Board of Medicine amended the Administrative Rules governing the Standards of Practice regarding the prescribing of sympathomimetic amine drugs, including amphetamines. The effective date of the Board rules was March 20, 1985. A copy of the rules, a brief summary and a narcolepsy waiver application was mailed to each licensee.

The rule prohibits MDs from giving, selling, prescribing or the administering of any of the sympathomimetic amine drugs designated in Schedule II under the Public Health Code for use in the treatment of obesity.

The sympathomimetic amine drugs designated in Schedule II include the following:

- Phenmetrazine (Preludin)
- Methamphetamine is marketed by several companies by generic name or brand names. Brand names include Desoxyn (Abbott Laboratories), Methampex (Lemmon), Zemoxyn (Zemmer Company) and Dee-10 (Scrip, Inc.). Generic companies include Rexar Pharmacal, Calvin Scott, C.L. Texton and Harvey Laboratories.

The above-mentioned products are banned for use in medical treatment in Michigan.

The rule permits the use of dextroamphetamine in the treatment of narcolepsy and hyperactivity in children and attention deficit disorder (ADD). There are further requirements that the rule imposes to permit the prescription of dextroamphetamine.

Compliance with all of the following in the treatment of hyperactivity or attention deficit disorder is required:

a. A complete history
b. A report from the child's school regarding the child's current and past behavior if the child is attending school
c. A complete physical examination including a neurological examination.

Treatment of narcolepsy with dextroamphetamine requires that an MD obtain a waiver from the Board. The Board has an application for the waiver which includes the following:

a. A summary of the substantiating data based upon a complete history and physical examination with appropriate studies including duration and clinical cause of the disease.
b. The written concurrence of another physician in the diagnosis and prescribing of dextroamphetamine for the patient involved.

Physicians are required to petition the Board for a waiver to use dextroamphetamine or the treatment of narcolepsy. The Board requires that the request be made on an application form form the Board on a per patient basis. A Board appointed committee considers the applications at each monthly meeting.

Upon meeting the criteria established for the use of dextroamphetamine as described in the above paragraphs, a physician is permitted to issue a written prescription in the following manner:

a. The entire prescription shall be in the physician's own handwriting.
b. The prescription shall include the purpose for which the drug is prescribed.

A violation of the rule constitutes a violation of Section 16221(a),(b)(i), (c)(iv) and (g) of the Public Health Code, 1978 PA 368, as amended. After a hearing, the board shall impose one or more of the following sanctions for each violation:

16221(a) - Probation, limitation, denial, suspension or revocation;

16221(b)(i) - Limitation, suspension, revocation or denial;

16221(c)(iv) - Fine, probation, denial suspension or revocation;

96221(g) - Reprimand, probation, denial, suspension, revocaton or limitation.☐

Mr. Fishman is Licensing Executive, Bureau of Health Services, Michigan Department of Licensing and Regulation.

By Catherine A. Fish

Laws and rules governing the physician

Drug abuse, and the resultant drug diversion situation, is a serious problem in Michigan and in the nation. Myriad laws, rules, and regulations have been implemented in an attempt to control the drug abuse problem by limiting public access to drugs that have abuse potential. This article describes the important provisions of these laws as they pertain to the prescribing of a controlled substance.

Schedules

Regulatory agencies in both the state and federal government classify or "schedule" drugs on the basis of their potential abuse liability. If a drug is deemed to have abuse potential, it is placed in a schedule and is considered a "controlled substance" subject to all the special controls and precautions of the Controlled Substances Act of 1970 (CSA), at the federal level and the Michigan Public Health Code, Act 368 of 1978 (PA368), at the state level. These two laws, the CSA and PA368, outline specific practitioner responsibilities in the areas of prescribing, administering, and dispensing controlled substances. PA368 defines a controlled substance as a drug, substance, or immediate precursor of a drug that has been placed in at least one of five different schedules. Drugs are listed in a schedule depending on their abuse potential, dependence liability, and accepted medical use as determined by the Michigan State Board of Pharmacy.

For example, Schedule 1 drugs have the highest abuse potential and have no accepted medical uses. PA368 contains a complete listing of the controlled substances found in each schedule. The *Physicians Desk Reference* (PDR) and the *USP DI, Vol. 1*, Drug Information for the Health Care Provider, both provide controlled substances schedule information based on federal requirements.

Licenses and records

In general, a controlled substance is "controlled" by virtue of the following:
A. Stringent licensing requirements of the state and federal law for persons who manufacture, distribute, prescribe or dispense controlled substances.
B. Extensive record-keeping requirements of the state and federal law for manufacturers, distributors and dispensers. Special records are required to be kept on Schedule I and II drugs.
C. Periodic inventory requirements.

A physician may prescribe a controlled substance in Schedules II through V provided the following items are obtained:
A. A controlled substance license from the Michigan Department of Licensing and Regulation.
B. A personal or hospital DEA registration number.

A physician that does not dispense controlled substances has no formal record-keeping requirements (except for those mandated by good medical practice) under the law since no product is handled. "A registered individual practitioner is not required to keep records with respect to narcotic controlled substances listed in Schedules II through V which he prescribes or administers in the lawful course of his professional practice; he shall keep records, however, with respect to such substances that he dispenses other than by prescribing or administering." So if a physician does dispense a narcotic controlled substances then he or she is required to keep records, perform inventories and file reports in conformance with the federal law. However, non-narcotic controlled substances are treated differently: "A registered individual practitioner is not required to keep records with respect to non-narcotic controlled substances listed in Schedules II through V which he dispenses in any manner unless he reguarly charges his patients, either separately or together, with charges for other professional services, for such substances so dispensed (when he substitutes his services for those of a pharmacist.)" CSA part 1304, sections .04, .11, .13, .17, .21, .24 apply to record-keeping requirements.

Prescription writing

In everyday practice, the rules that all prescribers and dispensers should be cognizant of involve the issuance of a prescription for a controlled substance. Two general requirements govern pre-

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Ms. Fish is Executive Resident, Michigan Pharmacists Association.

scription writing:

1. "A prescription for a conrolled substance to be effective nust be issued for a legitimate nedical purpose by an individual ractitioner acting in the usual ourse of his professional pracice. The responsibility for the roper prescribing and dispensng of controlled substances is pon the prescribing practitioner, ut a corresponding liability rests vith the pharmacist who fills the rescription."

2. "A prescription may not be ssued in order for an individual ractitioner to obtain controlled ubstances for supplying the individual practitioner for the purose of general dispensing to paients." A prescription order is for n individual patient. An audit trail f paperwork accompanies a ontrolled substance from the nanufacturer to the patient.

The following points will ensure he accurate interpretation and illing of a prescription:

- One prescription per blank.
- Make prescriptions legible.
- Provide age and weight data n pediatric/geriatric patients.
- Do not abbreviate drug ames.
- Always use the metric system.
- A decimal point is a legible part of the prescription.

Prescribing requirements for Schedule II drugs include:

1. Oral or phone orders of Schedule II drugs are not permitted except in cases of bona fide emergency. Prescriptions for Schedule II drugs must be in ink, or indelible pencil, or typewritten, and shall be manually signed by the practitioner. The prescriptions may be prepared by a secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations.

2. Schedule IIs are *not* refillable.

3. Emergency dispensing of Schedule IIs is allowed per oral authorization provided that:

a. The quantity prescribed and dispensed by the oral order is limited to the amount adequate to treat the patient during the emergency period.

b. The oral order is immediately reduced to writing by the pharmacist and contains all the information required above except the prescriber's signature.

c. If the prescriber is not known to the pharmacist, the pharmacist must make a reasonable effort to confirm the prescriber's identity.

d. Within 72 hours of the emergency oral order, the prescriber must send to the dispensing pharmacist a signed written order for the amount previously prescribed. The face of the order must say "Authorization for Emergency Dispensing."

Emergency situations means those situations in which the prescriber determines that:

1. Immediate administration of the controlled substance is necessary for the proper treatment of the intended ultimate user; and;

2. No appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II of the Act; and,

3. It is not reasonably possible for the prescribing physician to provide a written prescription order to be presented to the person dispensing the substance, prior to the dispensing.

Prescribing requirements for Schedule III and IV drugs:

1. Prescription orders for controlled substances in Schedules III and IV may be issued either orally or in writing.
2. Schedule III and IV drugs may be refilled. Such prescriptions may not be originally dispensed or refilled more than *6 months* after the issue date. Also, they can only be *refilled five times* after the issue date. If a physician wishes a patient to continue on the medication, a new prescripion order is required.

Prescribing requirements for Schedule V drugs:

1. A prescription for a Schedule V drug may be refilled only when expressly authorized by the physician on the prescription.

2. For Schedule Vs that are over-the-counter products, such as cough syrup with small amounts of codeine, the burden of determining the propriety of the dispensing is upon the pharmacist.

Application of state, federal law

In many cases, such as the amphetamine practice rule, state law is much more stringent than federal law and must be complied with in addition to federal law. For example, physicians should be aware of a Michigan controlled substance practice rule (Michigan State Board of Medicine rule 338.2303, Standards of Practice) regarding sympathomimentic amine drugs, including amphetamines. This rule states that the prescribing of any of the sympathomimetic amine drugs in Schedule II, Desoxyn, Dexedrine, Methampex, is prohibited except for in the cases of hyperkinesis or narcolepsy. (See article on amended amphetamine rules for details.)

Summary

It is obvious that the controlled substances laws are very specific and detailed. Intentional obstacles to prevent easy access to drugs with abuse potential make the laws complex. It is always "bad practice" to prescribe an excessive quantity of any medication, especially a controlled substance. This rule of reason would particularly apply to prescriptions covered by insurance plans where patients may pressure physicians for a supply exceeding one month.

Questions on controlled substances laws should be referred to the Board of Medicine or the Board of Pharmacy. A thorough knowledge of and adherence to these laws by prescribers and dispensers is essential in safeguarding your patients and the public from the dangers of drug abuse.☐

By the US Drug Enforcement Administration

DEA guide to obtaining and maintaining a controlled substance registration

Every physician who administers, prescribes, or dispenses any controlled substances must be registered with the Drug Enforcement Administration.

- "Administer" means to instill a drug into the body of the patient.
- "Prescribe" means to issue a prescription order for the patient.
- "Dispense" means to deliver controlled substances in some type of bottle, box, or other container to the patient. (Under the Act, the definition of "dispense" also includes the administering of controlled substances).

Physicians are required to register with the Drug Enforcement Administration, Registration Unit, PO Box 28083, Central Station, Washington, DC 20005. A physician who seeks to become registered must apply on Form DEA-224, which can be obtained from the Registration Unit or from any DEA field office. Complete instructions accompany the form.

The registration must be renewed annually and the certificate of registration must be maintained at the registered location and kept available for official inspection. Every physician currently registered with the Drug Enforcement Administration will receive a re-registration application approximately 60 days before the expiration date of his registration each year. If a registered physician does not receive such a form within 45 days before the expiration date of registration, notice of such fact and a request for the re-registration form must be made by writing to the Registration Unit of the Drug Enforcement Administration.

If a physician has more than one office in which he administers and/or dispenses any controlled substance, he then is required to register at each office. However, if a physician only administers and/or dispenses at his principal office and only writes prescription orders at the other office or offices, he then is only required to register at his principal office, where he administeres and/or dispenses, provided each place of practice within the same state must request modification of his registration.

Any physician who is an intern, resident, foreign physician, or physician of the staff of a Veterans Administration facility (exempted from registration), may dispense, administer and prescribe controlled drugs under the registration of the hospital or other institution in which the physician is employed, provided that:

1. The dispensing, administering, or prescribing is in the usual course of professional practice;
2. The physician is authorized or permitted to do so by the state where practicing;
3. The hospital or institution has verified that the physician is permitted to dispense, administer, or prescribe drugs within the state;
4. The physician acts only within the scope of employment in the hospital or institution;
5. The hospital or other institution authorizes him to dispense or prescribe under its registration and assigns a specific internal code number for each physician so authorized.
6. A current list of internal codes and the corresponding individual practitioners is kept by the hospital or other institution and is made available at all times to other registrants and law enforcement agencies upon request for purpose of verifying the authority of the prescribing physician.

In order for the Drug Enforcement Administration to curtail the diversion of controlled drugs, it is necessary for manufacturers,

Continued on page 538

Excerpted from *Physician's Manual, An Informational Outline of the Controlled Substances Act of 1970.*

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wholesalers, pharmacies, hospitals and certain physicians, among others, to keep records of drugs purchased, distributed, and dispensed. Having this closed system, a controlled drug can be traced from the time it is manufactured to the time it is dispensed to the ultimate user.

Narcotic drugs

A physician who prescribes and or administers narcotic drugs in the lawful course of professional practice is not required to keep records of those transactions. If a physician dispenses a narcotic drug to a patient, he is required to keep a record of such dispensing. In any case, the physician must keep complete records of all controlled substances "acquired" for a period of two years.

Non-narcotic drugs

A physician who regularly engages in dispensing any of the non-narcotic drugs listed in the schedules to patients as a regular part of professional practice, and for which charges are made either separately or together with other professional services, must keep records of all such drugs received and dispensed. The records must be kept for a period of two years and are subject to inspection by the Drug Enforcement Administration. (Dispensed as used above includes administering.)

A physician who has need for controlled drugs in Schedule II for use in his office or medical bag must obtain these drugs by the use of a triplicate order form. Order forms can be obtained by requesting them on the initial application form by checking block 4 of the Form DEA-224 or from the Drug Enforcement Administration, Registration Unit, PO Box 28083, Central Station, Washington, DC 20005. Once a registrant has obtained DEA order forms, a separate requisition form, DEA-222A, will be mailed to the registrant in order to request additional books. No charge is made for order forms.

The Federal Triplicate Order Forms should not be confused with the multiple-copy prescription blanks. The Federal order forms are to be used by a physician who has a need for a drug in Schedule II which is to be used in his office. For example, a physician must fill out a Triplicate Order Form in order to obtain Demerol or Morphine, etc. from the normal source of supply.

Prescription orders

A prescription order for a controlled substance may be issued only by a physician, dentist, podiatrist, veterinarian, or other registered practitioner who is:

1. Authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession; and

2. Either registered under the Controlled Substances Act or exempted from registration (military and Public Health Service physicians).

All prescription orders for controlled substances shall be dated as of, and signed on, the date when issued and must bear the full name and address of the patient, and the name, address, and registration number of the physician. Where an oral order is not permitted, prescription orders must be written in ink or indelible pencil or typewritten and must be manually signed by the practitioner. The prescription orders may be prepared by a nurse or secretary for the signature of the physician, but the prescribing physician is responsible in case the prescritpion order does not conform in all essential respects to the law and regulations.

A written prescription order is required for drugs in Schedule II and must be signed by the physician. The renewing of Schedule II prescription orders is prohibited.

A prescription order for drugs in Schedules III and IV may be issued either orally or in writing to the pharmacist and may be renewed if so authorized on the prescription. However, the prescription order may only be renewed up to five times within six months after the date of issue. After five renewals or after six months, a new prescription order is required either orally or in writing from the physician.

Telephone prescription

In the case of a bonafide emergency, a physician may telephone a prescription order to a pharmacist for a drug in Schedule II. In such a case, the drug prescribed must be limited to the amount needed to treat the patient during the emergency period. The physician must furnish, within 72 hours, a written, signed prescription order to the pharmacy for the drug prescribed. The pharmacist is required by law to notify DEA if he has not received the written prescription order within the 72 hours.

"Emergency" means that the immediate administration of the drug is necessary for proper treatment, that no alternative treatment is available and it is not possible for the physician to provide a written prescription order for the drug at that time.

A physician who discontinues practice must return his Registration Certificate and any unused order forms to the nearest office of the DEA. A physician having controlled substances in his possession at the time of discontinuing practice should obtain information from the field office of the DEA in his area and from the responsible state agency on how to dispose of these drugs.

A physician who has controlled substances stored in his office or clinic must keep these drugs in a securely locked, substantially constructed cabinet or safe.

It is recommended that the controlled substances stock should be kept to a minimum. Should it be necessary to have a substantial quantity of controlled substances stock stored in the office, DEA encourages having security which exceeds the minimum requirements, such as a safe and alarm system. Access to the controlled substances storage area should be restricted to the absolute minimum number of employees.□

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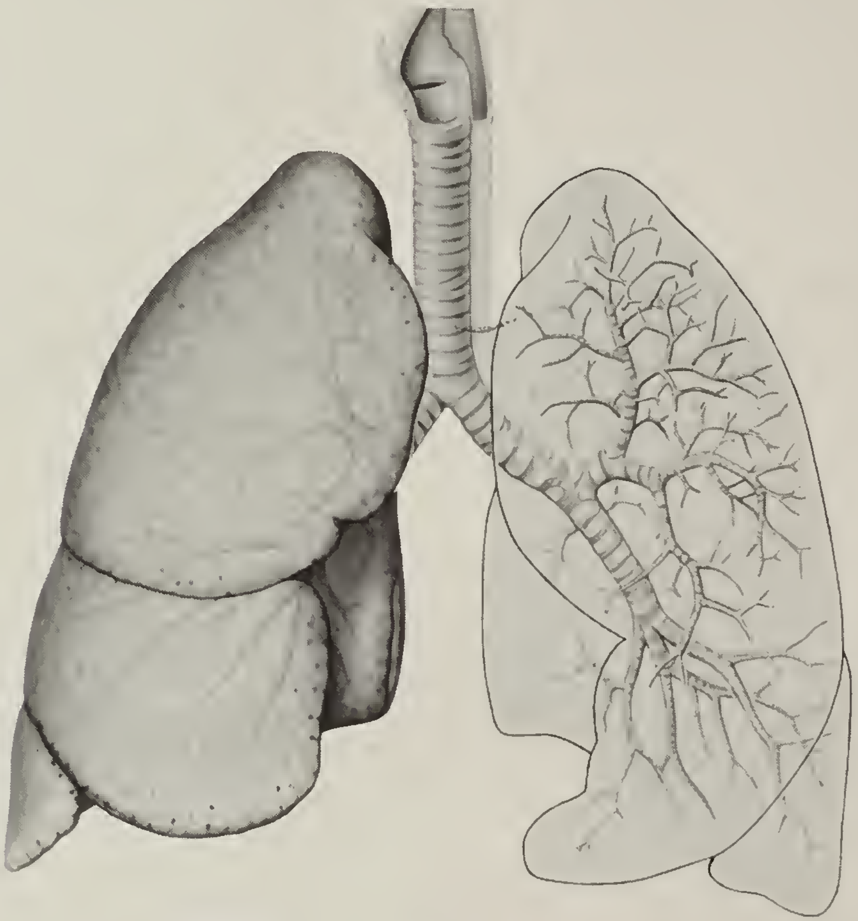

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Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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By Zoltan Turi, MD and Joshua Wynne, MD

Acute interventions in the early treatment of myocardial infarction

An educational article and CME quiz

With this article, the MSMS CME Programming Committee continues its medical education feature. A ten-question quiz follows, which may be completed for one hour of Category I credit.

Doctor Turi, a graduate of Columbia University College of Physicians and Surgeons, was recently recruited to Wayne State University from Harvard Medical School, where he was an attending cardiologist in the Cardiac Catheterization Laboratory at the Brigham and Women's Hospital. He currently is Director of the Cardiac Catheterization Laboratory at Harper Hospital, and Assistant Professor of Internal Medicine at Wayne State University. His major clinical and research interest centers on limiting the size of myocardial infarcts.

Doctor Wynne, a graduate of Boston University School of Medicine, was recruited to Wayne State University and Harper-Grace Hospitals in 1984 from the Brigham and Women's Hospital and Harvard Medical School, where he was Director of the Noninvasive Cardiac Laboratory and Assistant Professor of Medicine. As Chief of Cardiology for Wayne State University and Harper-Grace Hospitals, he has recently recruited a group of well-respected academic cardiologists to the Detroit Medical Center.

Remarkable progress has been made in this century in the treatment of acute myocardial infarction (MI). Much of this progress has occurred in the last decade and was made possible by a growing understanding of the causes of infarction. Thrombus formation, coronary artery spasm, and progressive atherosclerosis with myocardial oxygen demand outstripping supply have all been considered as potential causes. Thrombus formation in the coronary artery, a concept dating back to Herrick's description of MI in 1912, was considered controversial until recent experience with catheterization during acute MI demonstrated clot to be present in more than 90 percent of patients with transmural infarction. Attempts to reestablish blood flow during acute MI, rarely if ever attempted a decade ago, have led in the past several years to the most challenging and exciting innovations in MI management.

The modern era of acute intervention for MI began in the 1950s with the introduction of lidocaine, a readily titratable, relatively low-toxicity agent for controlling life-threatening arrhythmias. Until then, physicians were limited to conventional therapy consisting of bed rest, sedation, analgesics and oxygen, which continue to be effective and recommended therapy in 1985, but which did not diminish early hospital mortality below 30 percent. Antiarrhythmic therapy and modern coronary care units have now reduced the death rate by half.

Nevertheless, one out of six patients still die in the first hours to days of acute MI, and one out of 10 initial survivors die in the first post-MI year. Equally unfortunate is that many patients are severely disabled because of loss of myocardium with resulting symptoms of low cardiac output and congestive heart failure. Salvaging myocardium, and therefore improving survival and preserving quality of life in survivors, was a concept introduced by Braunwald in 1967. Two principles of preserving myocardium are now well understood:

1. Both the degree of ventricular dysfunction and mortality are directly related to the amount of damaged myocardium, and
2. Any intervention has to be initiated promptly if myocardium is to be preserved, preferably within 2 to 4 hours after onset of chest pain.

Interventions that lower myocardial oxygen demand

Only modest success has been attained with interventions that would limit infarct size by decreasing myocardial work. Trials of beta adrenergic blockers, nitrates, non-nitrate vasodilators, calcium channel blocking agents, and the intraaortic balloon pump have not consistently demonstrated decreased infarct size, preserved ventricular function, or improved survival. Nevertheless, we feel that beta adrenergic blockers are appropriate in selected patients in the first few hours of acute MI (in particular where sinus tachycardia is secondary to high catecholamine levels) and in most patients in the first few weeks post-MI when used for secondary prevention. We use nitrates prudently in patients with continuing chest pain, good systolic blood pressure, and normal or high ventricular filling pressures. Non-nitrate vasodilators, calcium channel blocking agents and the intraaortic balloon pump we reserve for selected patients, although calcium channel blocking agents appear to be particularly effective for post infarction angina.

Interventions that increase myocardial oxygen supply

The more aggressive, and exciting, interventions that have become the focus of innovative MI management have grown out of attempts to reestablish blood supply to ischemic and infarcting myocardium. These interventions, primarily thrombolytic drug therapy, percutaneous transluminal coronary angioplasty (PTCA), and coronary artery bypass surgery (CABG) have developed in parallel with our growing understanding of the mechanisms that cause MI.

Until quite recently controversial, it is now understood that acute MI is usually the result of thrombus superimposed at the site of a significant stenosis in a coronary artery. The combination of thrombus and coronary stenosis results in partial or total occlusion of blood flow; some degree of collateral blood flow may or may not be present. If the collateral circulation is sufficient to maintain viability of the heart muscle, total thrombotic occlusion can occur in a coronary artery without a resulting MI; this was demonstrated as far back as the 1940s. While large transmural infarcts are usually associated with thrombi, small patchy subendocardial infarcts can be found in the absence of coronary occlusion. Thus, thrombotic occlusion can occur with or without infarction and MI can occur with or without thrombosis. Furthermore, MI may be clinically silent. Because of these findings, the use of the term "coronary thrombosis" to refer to heart attacks was largely abandoned and replaced by the more general term "myocardial infarction."

The majority of patients with acute MI appear to have severe disease limited to one coronary artery; however, patients with multivessel disease may develop subendocardial MI without the formation of a thrombus, presumably the result of inadequate blood flow perfusing one or more of the narrowed arteries. The patients at highest risk of reinfarction and death after MI include those with residual large areas of viable myocardium with jeopardized perfusion. Identifying such areas of reversible ischemia (with exercising testing, with or without thallium scintigraphy) has become a useful clinical guide to the post infarction prognosis and management of patients.

Streptokinase

Streptokinase (SK), a protein produced by streptococci that activates plasminogen and thus results in clot lysis, is the most widely used thrombolytic agent in acute MI. Both intracoronary and intravenous SK are widely used (although the Food and Drug Administration has restricted approval to intracoronary SK in acute MI). Intravenous SK may have substantially lower efficacy in lysing coronary thrombi; by some estimates only one-third of patients receiving SK intravenously achieve early clot lysis, compared with two-thirds or more when SK is given intracoronary. Intracoronary SK has the advantage of maximizing the concentration of the agent at the site of the coronary thrombosis; intravenous SK has the advantage of quick administration, not requiring the time needed to mobilize a cardiac catheterization team.

Streptokinase has substantial drawbacks in acute MI therapy. It can cause life threatening allergic reactions, particularly when infused a second time. Even with intracoronary administration, it usually produces a systemic lytic state, and has been associated with fatal generalized hemorrhage, intracranial bleeding, hemorrhage into the pericardium with tamponade, lysis of old left ventricular mural thrombi with secondary stroke, and possibly accelerated myocardial rupture. Intracoronary streptokinase, while simultaneously more effective at clot lysis and responsible for less systemic fibrinolysis, requires cardiac catheterization. The latter significantly delays intervention and potential reperfusion, is associated with some additional morbidity/mortality, and if adopted as routine health care policy for all acute MIs would tax an overburdened health care system considerably by requiring cardiac catheterization teams to be available on 24-hour call at hospitals throughout the nation.

Furthermore, the overall efficacy of streptokinase remains controversial. While up to 80 percent of patients may have successful clot lysis (with intracoronary SK), it is yet to be established that this translates to lower morbidity and mortality. Uncontrolled trials have suggested an improvement in left ventricular function after successful thrombolytic therapy, but the randomized studies to date have shown little or no change in either global or regional left ventricular function when all patients given SK are compared to controls.

Patient survival does not appear to be dramatically improved. Although a moderate-sized multicenter controlled trial (the Western Washington Thrombolytic Trial) demonstrated initial improved survival in patients treated with intracoronary SK, late follow-up at one year has not revealed any significant difference in overall mortality between treated and untreated patients. The study did demonstrate a difference in one-year mortality within the SK treated group, with improved survival in patients who reperfused, and in particular among those who had anterior wall infarcts (95 percent of patients with anterior wall MI who reperfused were alive at one year compared with only 64 percent of similar patients who did not achieve reperfusion). However, reperfusion is a retrospective, not prospective finding; the clinician who decides to give steptokinase does not know ahead of time if reperfusion will be achieved. Furthermore, reperfusion may be coincident with better prognosis rather than the cause of it; one must also keep in mind that a significant minority of patients undergo *spontaneous* clot lysis.

Tissue plasminogen activator

Unlike SK, which activates plasminogen throughout the vascular system, tissue plasminogen activator (t-PA) acts at the site of thrombus formation by activating plasminogen principally on the surface of fibrin, thus producing thrombus-specific thrombolysis. Initially harvested from a human melanoma cell culture, t-PA is now being produced through recombinant DNA technology (rt-PA). Limited initial experience with *intravenous* rt-PA has suggested that it is as effective as *intracoronary* SK. The potential advantages of rt-PA are many: found in miniscule amounts in human tissue, it is not thought to cause the allergic reactions seen with SK; it causes less (if any) systemic fibrinolysis; it has a substantially shorter half-life than SK; and, most importantly, its effectiveness intravenously is proven. It may be appropriate to use t-PA in the early emergency care setting, thus minimizing the amount of time between onset of necrosis and reperfusion. Unlike SK, t-PA is not yet available commercially, but it and two other similarly acting agents, acyl SK and prourokinase, hold great promise.

Percutaneous transluminal coronary angioplasty

A residual coronary artery stenosis at the site of the prior occlusion is the rule in most patients undergoing successful thrombolytic therapy. Without a second intervention aimed at *maintaining* adequate blood flow down the artery, continued ischemia and reinfarction is common. Streptokinase or t-PA alone may not change, but merely delay, the natural history associated with a given coronary stenosis.

With the demonstration that a coronary stenosis can be dilated with PTCA, many centers have followed successful thrombolysis with angioplasty. This approach may be particularly attractive in the setting of acute MI, since upwards of half the MI patients may have single vessel coronary artery disease. While single vessel coronary disease frequently can be managed medically, the malignant nature of a stenosis that has been demonstrated to lead to MI often tips the clinician's hand toward further intervention. Because of the major drawbacks inherent in streptokinase administration, and with growing experience with PTCA, we now perform PTCA acutely, without antecedent thrombolytic therapy (Figures 1, 2, and 3). Penetration of the clot with a guidewire and subsequent dislodgement of clot and dilatation of the coronary stenosis by the PTCA catheter essentially combines two procedures. Typically, the dislodged clot breaks into fragments and undergoes spontaneous thrombolysis. The elimination of a residual stenosis diminishes the likelihood of reocclusion or further ischemia. The drawback, however, is the need for a cardiac catheterization team to be available to perform the procedure within a few hours after the onset of chest pain. It is important that only the vessel causing acute MI be dilated, leaving stenosis in any other vessels for dilatation at a later date if necessary, because of the demonstrated increase in morbidity when several vessels are dilated in the acute MI setting.

Coronary artery bypass surgery (CABG)

Emergency bypass is the third method available that may restore coronary perfusion in patients with acute MI and coronary occlusion. It normally has the advantage of correcting *all* the stenoses present, but must be performed early. The challenges of having an operating team on 24-hour alert are obviously much more formidable than those associated with keeping a cardiac catheterization team available; the number of patients geographically close enough to an experienced open heart center is also a limitation.

Conclusion

It is now well established that all three methods of reperfusing infarcting myocardium—thrombolysis, PTCA, and CABG—can result in effective restoration of blood flow. However, the feasibility of these methods does not imply that they should be used routinely, since their beneficial effect on mortality or ventricular function has not been established definitively. Until the results of ongoing clinical trials are completed, these methods should be considered experimental, although holding great promise for the future.

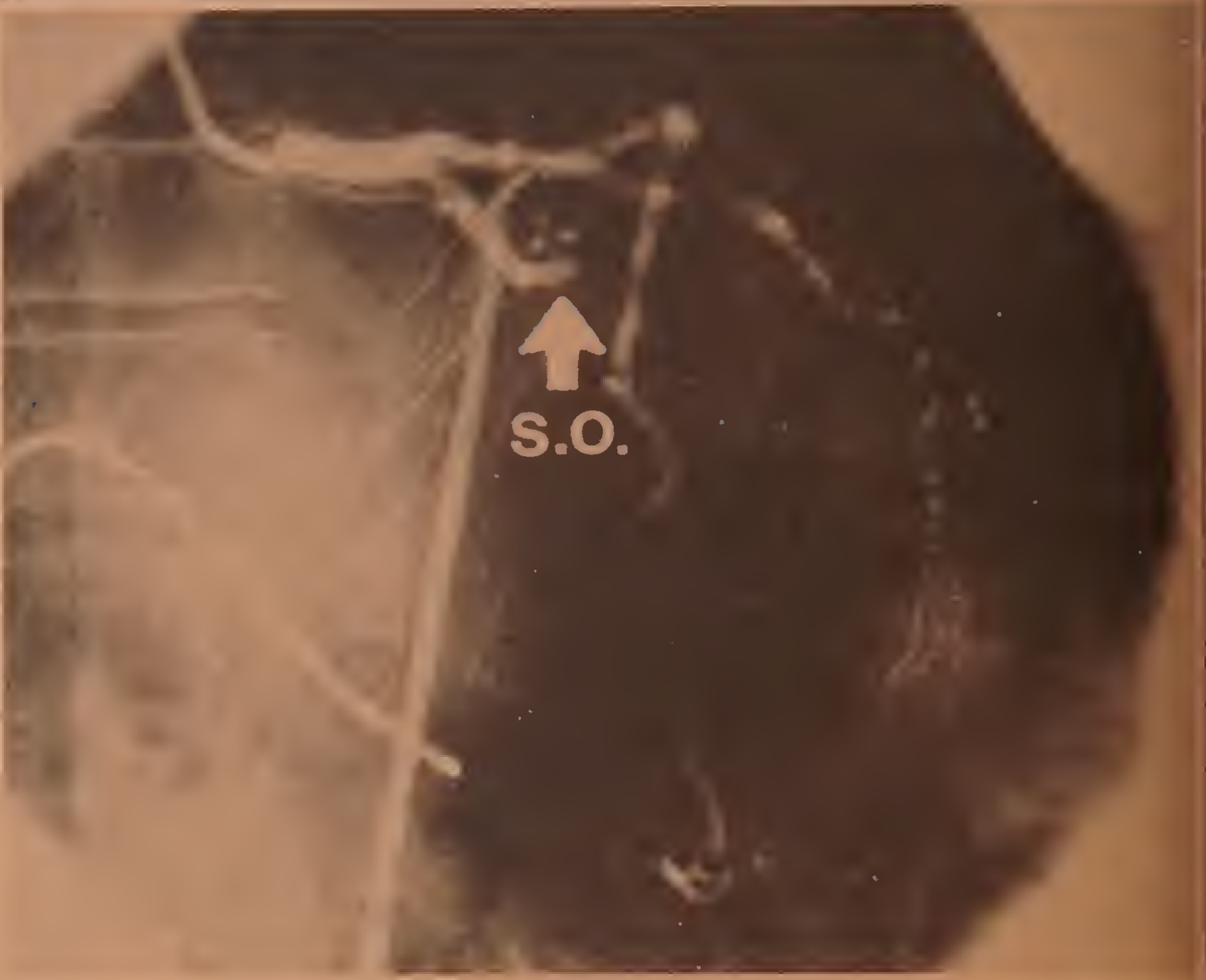

Figure 1

Coronary angiogram of left coronary artery of a patient studied at Harper Hospital, with total segmental obstruction (S.O.) of the left circumflex coronary artery. The remainder of the left coronary artery is patent. There is a pacing catheter in the right ventricle (lower left corner).

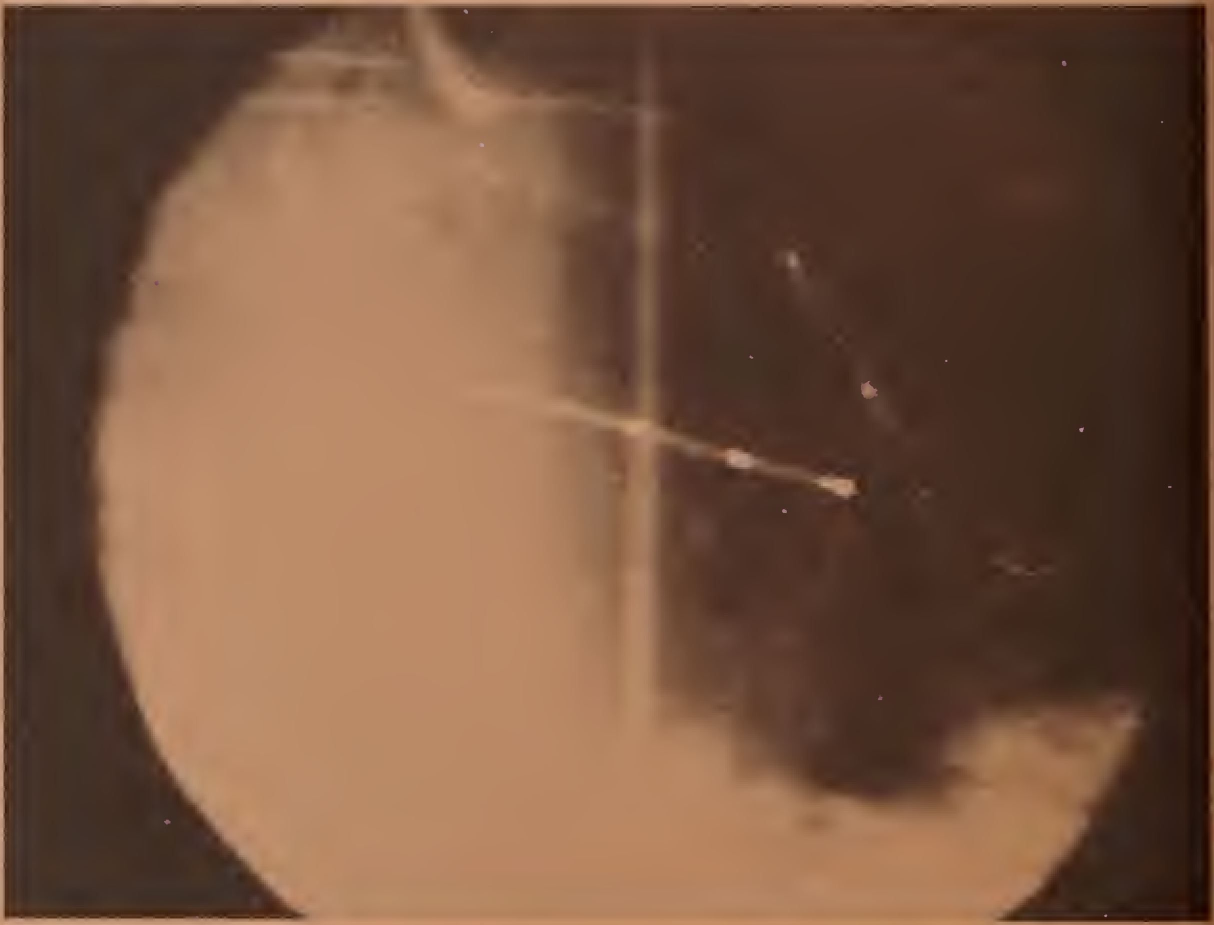

Figure 2

Inflated PTCA catheter across the site of prior occlusion due to thrombus. The sausage-shaped balloon has been inflated between the two radio-opaque markers. The guidewire extends distally (toward the lower right) along the course of the coronary artery.

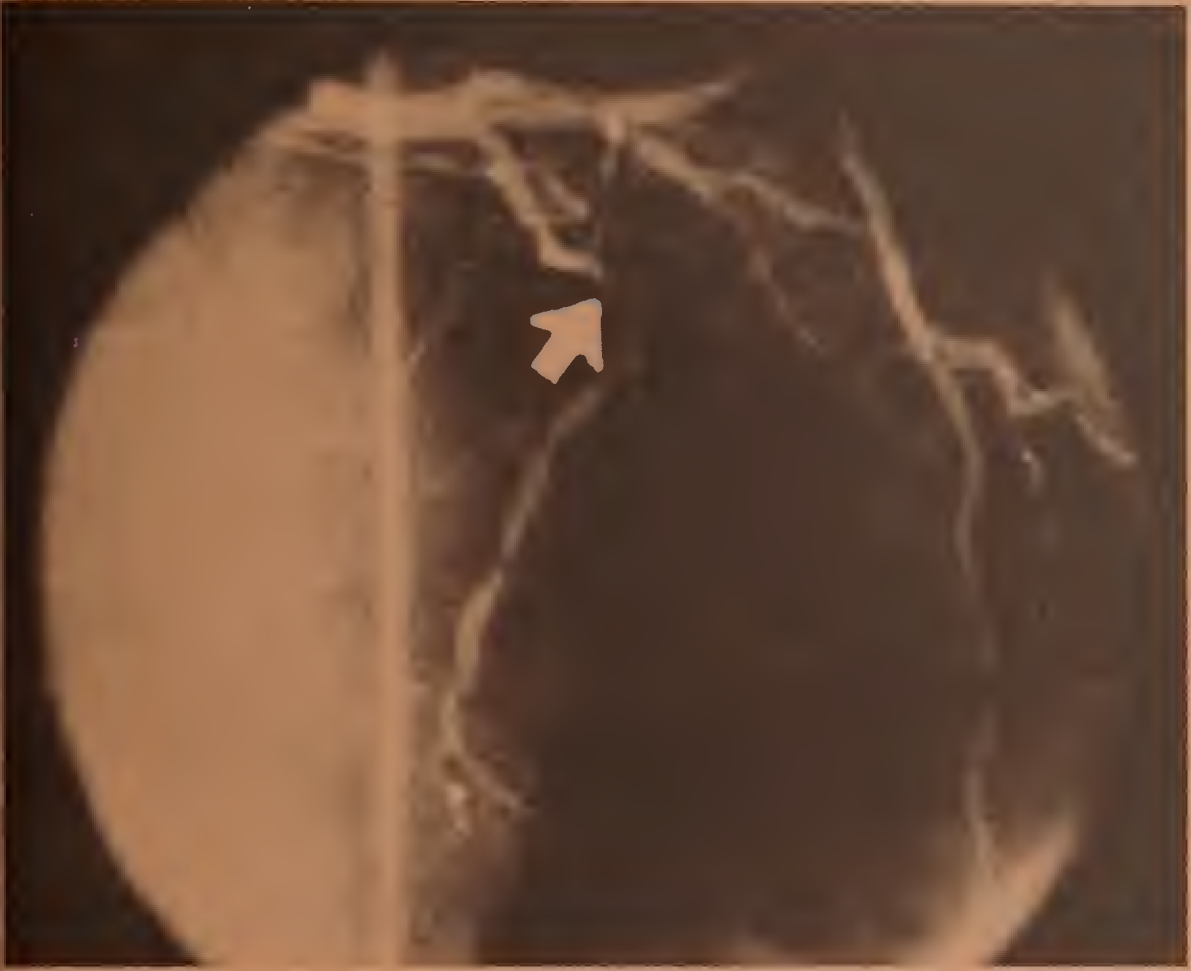

Figure 3

Coronary angiogram of left coronary artery after successful penetration of the thrombus and dilatation of the stenosis, with excellent reperfusion of the circumflex coronary artery system. The arrow indicates the site of prior segmental obstruction, now totally eliminated. (The pacing catheter has been removed)

Turn to next page for a CME quiz

→

CME Quiz

Acute Intervention in the Early Treatment of Myocardial Infarction

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation certifies that this activity meets the criteria for a maximum of one credit hour in Category I toward the requirements for Michigan relicensure and of the Physican Recognition Award of the AMA provided it is completed as designed. To obtain one hour of Category I continuing medical education credit, please answer the following questions by circling the correct answer. **Mail this page to Sherry L. Fent, MSMS, 120 W. Saginaw Street, East Lansing, 48823. Be sure to include a $3 administrative charge. Deadline: December 1, 1985.**

1. The current hospital mortality of MI is approximately:

a. 5 percent
b. 15 percent
c. 30 percent
d. 40 percent

2. The mortality in the first post-MI year averages about:

a. 5 percent
b. 10 percent
c. 15 percent
d. 20 percent
e. 25 percent
f. 30 percent

3. (T or F) Over 90 percent of *all* infarcts, regardless of location or type, are caused by a coronary thrombosis.

4. (T or F) A coronary thrombus appears to occur *secondarily* after an MI.

5. (T or F) Coronary thrombi can occur without infarction, and MI can occur without thrombosis.

6. (T or F) In transmural infarction, most patients studied early will have a tight coronary stenosis and a superimposed thrombus, resulting in total occlusion of the artery.

7. (T or F) The *major* determinant of a high-risk patient after MI relates to electrical instability of the myocardium.

8. Which of the following statements is/are true?

a. t-PA can be produced by recombinant DNA technology.

b. Streptokinase may be given by either intracoronary or intravenous routes, with similar results and risks.

c. Thrombolytic therapy has been demonstrated to be effective therapy in MI since spontaneous clot lysis is rare.

d. Tissue-type plasminogen activator usually results in a systemic lytic state.

9. (T or F) One of the advantages of doing a coronary angioplasty in the acute setting of an MI is that all coronary stenoses can be dilated in one setting.

10. (T or F) One of the challenges with all methods of reperfusing infarcts is that the therapy must be instituted within 12 hours after occurence of the occlusion, or it is unlikely to be successful.

I wish to apply for one hour of Category I CME through the MSMS Committee on CME Programming. I understand that my answer sheet will be graded confidentially, and that notification of my successful completion of the quiz (80 percent of the questions answered correctly) will be sent to me. I also understand that if I do not answer 80 percent of the questions correctly, I will not be eligible for the one-hour Category I credit but may record and/or report the activity in Category V.

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By Sheri Greenhoe,
Managing Editor

Annual Scientific Meeting courses are filling up!

Register today for the best selection of courses at this year's Annual Scientific Meeting, November 12-13-14 at the Hyatt Regency Dearborn. ASM staff coordinator Sherry L. Fent says registrations are ahead of last year's, and with good reason.

Acting ASM chairman Samuel M. McMahon, MD, has vowed to make this year's session "the best Annual Scientific Meeting ever." He and his committee have had to work hard to try to top past meetings, and have planned the following highlights:

- "From here to eternity" is the theme of two sets of three alpha-omega courses which study the disease process through the early, mid- and later years.
- More than 20 special events are planned in addition to the courses. They include specialty society functions, clinical poster presentations, medical school receptions, an investment seminar and a variety of business meetings.
- Seventy exhibitors will display and demonstrate products and services in the Great Lakes Exhibit Hall where you can enjoy coffee and deli lunches between classes.

All this, as well as 53 quality CME courses to choose from — what are you waiting for? Register today for the 1985 MSMS Annual Scientific Meeting. Use the form on the next page. (For complete course descriptions, see your September issue of *Michigan Medicine*, or contact Sherry Fent at MSMS headquarters.)

Register on the next page →

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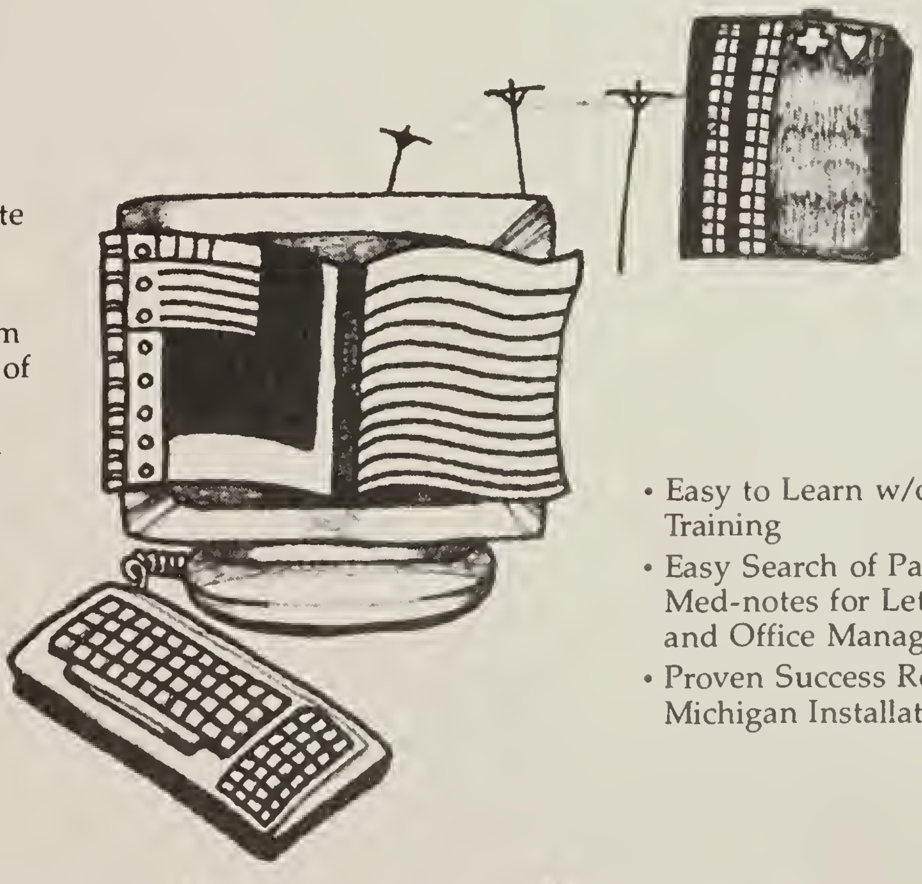

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Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

TUESDAY MORNING, NOV. 12
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Carcinoma of the Prostate: Current Management
____ Environmental Emergencies
____ Evaluation and Treatment of Metastatic Colon Tumors in the Liver
____ Hypertension and Aging
____ Management of the Spinal Cord-Injured Patient in General Practice
____ Occupational Health Concerns of the General Medical Community
____ Rheumatology 1985: Osteoporosis, Hyperuricemia and Gout
____ Type I Diabetes and Related Problems

TUESDAY AFTERNOON, NOV. 12
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Clinical Applications of Magnetic Resonance Imaging
____ Focus on Aging: Depression
____ Headache, TMJ Syndrome and Sinus Disease: Which is Your Patient's Problem?
____ Low Back Pain: A Practical Treatment Approach
____ Lower Extremity Sports Injuries: Identification and Management
____ Management of Common Pain Syndromes
____ Organ Transplantation and the Community Physician
____ Pulmonary Disease in Pediatrics
____ Selected Topics in Nuclear Medicine for the Practicing Physician

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Please check the courses you wish to attend. In each case, please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/17/85 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

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(8:30 to Noon, including break)
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____ Common Surgical Problems in Infants and Children
____ Diabetes in the Mid-Years
____ Evaluation and Treatment of the Dizzy Patient
____ Gait Problems – A Pathway to Diagnosis
____ Industrial Injuries: Evaluation, Prevention & Management
____ Melanoma & Precursor Lesions – Advances In the 80's
____ New Aspects in Hormone Therapy for Women
____ Treatment Options for Malignant Brain Tumors

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(Write 1 in blank for first choice and 2 for second choice)

____ Allergy and Asthma Update
____ Chronic Abdominal Pain
____ Cumulative Trauma Disorders and Ergonomics In Industry
*____ Industrial Support of Medical Research and Treatment in Surgery
____ Infectious Illness in Children
____ Neurological Problems of General Interest and Frequent Encounter
____ Occupational Lung Disease
____ Physician's Role in Diagnosis and Care of the Sexually Abused Child
____ Recurrent Urinary Tract Infections Update
____ What's New in Dermatology

THURSDAY MORNING, NOV. 14
(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Child Psychiatry: An Update in Common Disorders
____ Diabetes in the Elderly
____ Evaluation and Treatment of the Painful Ischemic Lower Extremity
____ Genetics Before and After Birth
____ The Retina and Kidney – Diabetic Weathervanes
____ Update in Office Infectious Diseases
*____ What's New in Cardiac Surgery

THURSDAY AFTERNOON, NOV. 14
(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

*____ Cataracts: Concepts and Complications
____ Inflammatory Bowel Disease
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On being an expert witness

"On Being an Expert Witness" is the title of one chapter of *First Frontiers,* memoirs of Christopher Stringer, MD, published this fall by Enterprise Press. That chapter, an entertaining account of Doctor Stringer's courtroom experience, is published here in its entirety. The chaotic courtroom story, not likely to be repeated nowadays, makes for delightful reading.

Doctor Stringer is an MSMS member and retired thoracic surgeon. Over the years he has been active in specialty and county medical society leadership roles, and is known for his early efforts to bring specialized chest medicine to the Upper Peninsula and to TB sanitariums around the state.

My long-time friend, Doctor Charles Bailey, a renowned chest surgeon in New York, had the right idea. He became so concerned about the courts, the lawyers and the legal process that he went to law school and became a lawyer. He is now an internationally known chest surgeon and a lawyer. I suspect Charley did this in order to provide some degree of protection for himself and his colleagues from the unpredictability of the legal process. It's a complete puzzle to me—and as the years have passed, legal proceedings have sometimes become downright irritating.

Attorneys have asked me for help and advice. I've also been subpoenaed. Either way, they make a point of cautioning me to tell the truth. I find this annoying for two reasons. One, if a lawyer has any doubt about the honesty of his witness, why is he or she seeking his help?

Two, the same attorney who reminds his or her witness to tell the truth will often try to prevent the opposing witness from doing so. I've been told this is called the adversary process. Whatever that means.

There is also testimony considered "inadmissible evidence" and the frustrated witness who has sworn to tell the "whole truth and nothing but the truth" is often prevented by the lawyers and the court from doing so if the testimony is considered inadmissible. I've never been able to understand or even extract a definition of what kind of evidence is inadmissible from a lawyer.

Worse, there is the spectacle of two opposing lawyers yelling in apparent anger at witnesses and at each other, and walking out arm in arm at recess, evidently in high spirit at the prospect of lunching together and replaying conversationally the morning's session.

During my training years in chest surgery, I was responsible for the care of a patient with advanced tuberculosis. Somehow this unfortunate man fell into the clutches of a labor lawyer named Andrews, who brought suit against the patient's former employer, Chrysler Corporation, alleging that the man had silicosis, an occupational disease. This was before the enactment of our present compensation law and a litigant could claim any amount he and his lawyer wanted to. Andrews phoned and asked for my help, so I arranged to meet him in my sparse little office. I wasn't very high in the hospital echelon and this cubicle, which had a wash basin, a battered old desk, desk chair and one creaky straight chair in front of the desk for visitors, was tucked away on the fifth floor of Detroit's Herman Kiefer Hos-

By Christopher Stringer, MD

pital. The toilet was discriminatory. Once inside, a fat person could not have shut the door. Everything needed a coat of paint. I directed lawyer Andrews to the straight chair across from where I sat.

Andrews was eager.

"Doctor Stringer, your patient and my client can use your expertise in presenting his case to a court jury."

"I'll do what I can," I said. "How do you plan to proceed?"

He licked his lips. "I intend to prove that a certain operation at Chrysler is an occupational hazard. As a chest doctor, you would be my expert witness."

"I understand that part," I said. "On what grounds do you intend to build your case?"

"That my client is ill because Chrysler has been negligent in providing a safe environment for workers." He warmed to the vision of sympathy he hoped to evoke. "I figure my client is so ill from silicosis because of his work exposure, he should not have to appear in court but, since he should testify on his own behalf, I would order a stretcher for him."

I was beginning to dislike the man.

"No, you won't!" I heard myself speaking too loudly. "That would be unfair — and unsafe for the patient and people with whom he would come in contact."

"Doctor Stringer," he said, putting on a pious face, "just think of all the other workers being subjected to these same hazards—there must be 200 or 300 men in that department who could be sick with this very same lung disease. I could get for them what's due them."

"I'll say it again — my patient does not have silicosis . . . "

"No, Mr. Andrews," I was emphatic. "My patient does not have silicosis, he has tuberculosis."

He seemed not to hear.

"As an expert witness, you can help." He indicated my barren little office with a tossing gesture as if he were already throwing bribe money my way.

"You staff physicians can always use extra cash, and there would be plenty if I can win this case."

I could feel blood rush to my face.

"Mr. Andrews, you aren't interested in the truth or you would have heard me the first time." I strained to keep my voice level. "You're only interested in winning—right or wrong. I'll say it again—my patient does not have silicosis, or any other occupational disease. There is no way I can help you."

It sank in this time. Pressing his lips into a thin line, he slammed his briefcase shut and stomped out. The heavy footsteps were the last I heard of Andrews until months later.

* * * *

"Doctor Chris Stringer?" The stranger in the dark business suit stood in the doorway of my office, one hand in his pocket.

I identified myself and his hand emerged from the pocket holding a subpoena. It had been issued by Chrysler's attorney, a man named Collins. I had no choice, I was bound to be a witness in the "Chrysler Case."

I got busy and assembled information about my patient, then summarized it all. It took considerable time and energy. There was so much material, including x-rays, that it needed two clerks from the hospital record room and myself to carry it.

The three of us trundled down to the federal building in Detroit. Later, when I was called to the witness stand, I handed over the remaining medical charts, nurses' records, x-rays and correspondence to my two helpers.

"You are not to release these to anyone but me unless you are ordered to do so by the court," I instructed the clerks.

The trail had been in progress for more than a week and I had sat in the audience part of the preceding day to observe what evidence the crafty plaintiff attorney Andrews presented. He

Continued on page 554

had found three former fellow employees of my patient who testified primarily about conditions in their working area at the Chrysler factory. Andrews did have a medical doctor witness whom he finished direct-examining just before noon recess. This man testified that my patient did not have tuberculosis but did have silicosis, an occupational disease.

Lunch hour came and the court recessed. I made my way over to Attorney Collins.

"You should further explore this doctor's qualifications," I suggested to him. "I know or know about every qualified medical person connected with chest diseases in the area, and I've never heard of this man."

"Good point." Collins made quick notes on his yellow pad. "Anything else?"

"Yes — ask him to tell the court what kind of dust was alleged to permeate the air in the factory."

Collins went to work when the court reconvened. In moments, he had discredited the "expert witness." When asked if the dust in the air was due to silicon dioxide particles, the witness said no. He didn't even know that silicon dioxide has to be present in the dust to cause silicosis. That is where the disease gets its name.

Antagonistic Andrews was able to see his evidence for silicosis was close to destruction so he switched tactics. He tried to prove that the patient's tuberculosis was due to working conditions. This was a more reasonable consideration but still a discredit to the truth.

"When you cross-examine the doctor again," I whispered to Collins, "ask him to name the germ that produces tuberculosis."

Collins nodded. Shortly he re-cross-examined the doctor-witness.

No, the "expert" witness couldn't name the exact organism and said there were several.

I knew this would be his answer, yet I felt embarrassed and sorry for the fellow. At the first opportunity, I leaned towards Collins. "Lay off — the poor guy just isn't qualified and obviously the court realizes this."

"I did prove my point, didn't I?" Collins said smugly.

At 4 o clock court adjourned.

"I have other witnesses to call, your honor," Andrews said.

Judge O'Brien recognized his petition and set the court time for the next morning.

I stayed on the job at the hospital that next morning and was eating lunch when Collins phoned.

" . . . Collins identified me as the patient's physician, something everyone already knew."

"Court reconvenes at 1:30 today and you're going to be called to the stand at that time." He spoke rapidly.

"All right, we can make it if we hurry." I hung up, notified the record room clerks and the three of us dashed downtown to the courtroom, again loaded with medical records.

On the stand, I answered Collins' questionsd easily enough. With almost a flourish, Collins identified me as the patient's physician, something everyone already knew. Andrews was strangely quiet but wrote with a pencil on a legal pad as fast as he could.

I testified that my patient indeed had pulmonary tuberculosis, not silicosis, and I described how the diagnosis had been made. I named the causative organism and how it had been found in the material from the patient's lungs.

Abruptly, Collins digressed from his line of questioning. I was uneasy — he had not told me of any change of tactics.

"Doctor," he asked, "have you ever seen the counsel for the plaintiff prior to seeing him here in this courtroom?"

"Yes."

"Where?"

"In my office." I was abrupt.

"Where is your office?"

"At Herman Kiefer Hospital."

"Why was he there, Doctor?"

"He said he was there to discuss my patient."

"Did he ask you to testify that your patient had silicosis?"

"Yes."

There was a sudden flurry of motion and sound from Andrews' position at the long table. He leaped from his chair, nearly knocking it over backwards. The court watched, in surprise as he snapped his pencil in two and rushed toward me. Trapped in the witness chair, I could only wonder what theatrics were coming. Up came his arm, and the fist began to shake. My god, I thought incredulously, he's aiming it at me!

"That is a lie," he shouted. The fist was now under my nose.

Like his pencil, something in me snapped. I forgot where I was and why I was there. Rearing back, I planted my foot in his midriff and pushed. He staggered backwards. Now free to move, I leaped to my feet, drew back and delivered one cracking punch to the side of his jaw.

This changed his course of direction. He flew against the judge's bench and landed in a heap.

Horrified at what my reflexes had done, I stood uncertainly while the bailiff helped him up. My hand hurt and my wrist, when I glanced down at it, appeared to be starting to swell. Fleetingly, I thought about broken bones. A plaster cast would play hell with the surgery I was supposed to be doing.

Judge O'Brien's gavel came down and in the uproar, his voice was all but drowned out.

Continued on page 556

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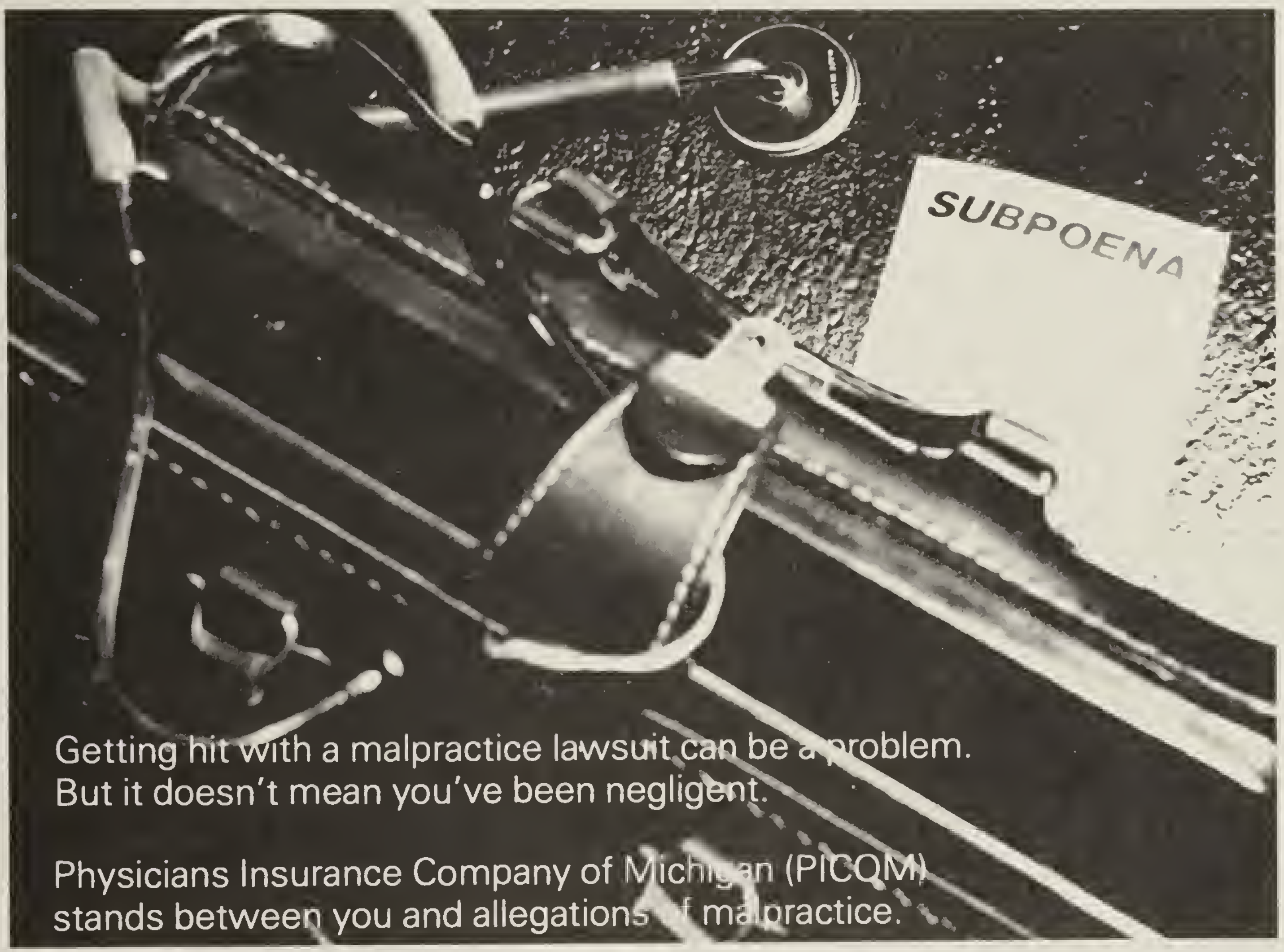

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"The bailiffs will clear the court! Members of the jury, you are excused!"

He turned an impassive face to the two attorneys.

"Both counsels will please come with me to my chambers."

After the judge and the attorneys and the jury exited, the others in the courtroom, including other witnesses, burst into a circus of sound and motion. The three of us from Herman Kiefer made our way to the corridor, followed by most of the others in the courtroom. All were milling about the corridor.

An hour went by. I was greatly concerned. The court had every right to find me in contempt and Andrews could probably charge me with assault and battery.

A well-dressed man came up to me and said, "That man deserved what you did to him, but you may be in trouble. If so, we will certainly defend you and I will speak to Mr. Collins about it." He was a Chrysler official who had been sitting in court all the time and I didn't know it.

Finally, court reconvened. We all rose at the bailiff's "Hear ye, hear ye! This court is now in session."

Judge O'Brien appeared from the paneled doorway at the back of the bench, his face creased in displeasure. From my seat in the courtroom, I stared. Were the corners of the judge's mouth twitching? I couldn't tell from a distance and I was too worried to consider the possibility for long. He could even impose a jail sentence on me. I wished heartily I never had heard of my tuberculosis patient and his nasty lawyer.

The judge directed me back to the witness chair and the jury was recalled. The record room women, still clutching the precious files, were trying to suppress their desire to laugh aloud. They shivered and their eyes watered with the effort to contain themselves.

Judge O'Brien gaveled the court to order. "This could and possibly should be a mistrial," he said to the counsel and jury. "These parties, however, and the government, have already gone to considerable expense over a period of nine days. We will, therefore, proceed."

He turned to the jury.

"You are to disregard what counsel Andrews said to the witness and what the witness did."

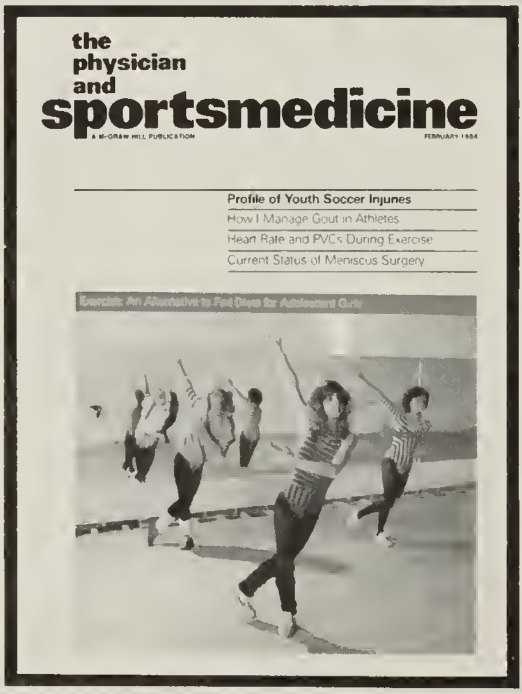
At this, the record women's faces screwed up and they ducked their heads. I wondered how long they were going to be able to contain themselves.

The judge leaned back in his chair.

"You may proceed, Mr. Collins."

* * * *

On the witness stand again, Collins asked me a few more simple questions regarding the diagnosis of silicosis and ended his direct examination.



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"Your witness, Mr. Andrews," Judge O'Brien said.

"No questions, your honor."

"Mr. Collins."

"No further questions, your honor."

I was excused from the stand. Collins stated the defense had finished — Andrews said they had no more witnesses.

Judge O'Brien read brief instructions to the jury, then excused them for deliberations.

Attorney Collins touched my arm.

"Doctor, while we're in recess will you come with me?"

"Of course," I signaled the record room clerks and they hurried over, the files cradled in their arms. Their faces were not quite composed. We had not used a single additional item in the trial!

We stood uneasily in the little room.

"Mr. Collins," I asked. "why did you rest your case so abruptly? I thought you said Doctor Gardener would be here to testify tomorrow." Doctor Leroy Gardener was a famed silicosis expert from the Sarnac Lake Laboratory and one of my former teachers. I had been looking forward to seeing him again.

"After your act, we don't need Doctor Gardener," Collins said. "I wired him not to come and I'll write him later with an explanation."

"I'd rather you didn't," I said pointedly.

Not knowing whether the jury would be out an hour or a week, my record room assistants and I left the federal building. I was glum. "Ladies," I said, groping for words, "Please don't report my fiasco..."

Unable to restrain themselves any longer, the women burst into laughter. They giggled in the car all the way back to the hospital and were still twittering when I dropped them off. The hospital staff, incredibly, had heard the story before I even drove into the physician's parking lot. I was met by a barrage of grinning colleagues. One of them handed me a message to call Mr. Collins at his office.

I dialed the number, feeling like there were egg beaters turning in my stomach.

"Doctor Stringer," Collins was exuberant, "The jury returned a verdict in our favor. You may have saved Chrysler more than a million dollars."

"Nice work, Mr. Collins. But, I don't think I'll ever be the same again." I hung up. The only positive thing from this horrible episode was that my hand and wrist were not injured.

About two weeks after the trial, I received a letter from Judge O'Brien apologizing for Attorney Andrews' behavior in the judge's court. There was no reference to my decking the man.

Walter Chrysler, founder and then chairman of the board of Chrysler, wrote me a letter of appreciation along with an autographed copy of his recent biography. I loaned the book to one of the Chrysler engineers and never got it back.☐

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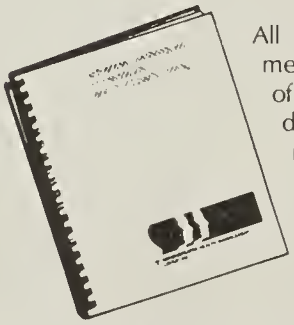

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By A. Stewart Kerr, JD

FTC gets involved in regulation of the professions

The Massachusetts Optometry Board is the licensing authority in that state for optometrists. In a brand new FTC administrative complaint it is alleged that the Board furthered its illegal "conspiracy" by three types of regulations:

- Regulations prohibiting ads offering free services, rebates, discounts, refunds or other such offers to increase clientele without regard to the truth of the ads.
- Regulations prohibiting ads containing testimonials and "flamboyant" or "sensational" ads.
- Regulations prohibiting optometrists from allowing optical or other commercial establishments to advertise or publicize their names or services.

The Board then allegedly forced and intimidated optometrists into compliance with improper Board regulations by these methods:

- Sending investigators to interrogate optometrists and to inform them that their advertising was improper.
- Demanding that optometrists attend meetings at which the Board would instruct them to stop their ads.
- Bringing or threatening to bring disciplinary action against optometrists for certain advertising.

Why is this of current interest to MSMS? Because FTC, a federal agency, has filed litigation against a state board. It is generally thought that, in the absence of a preempting federal statute, appropriate "state action" such as a board's regulatory rules control such intrastate licensing matters. Here, however, FTC has charged a state board with a conspiracy to carry out what are deemed to be illegalities under federal law.

As the complaint was issued on July 8, the end result may be years down the line. Nonetheless, we shall attempt to follow this and all other federal incursions into the realm of state regulation of the professions and quasi-professions.☐

Mr. Kerr is an attorney with the Detroit firm Kerr, Russell and Weber, MSMS legal counsel.

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Continued on page 562

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Continued on page 569

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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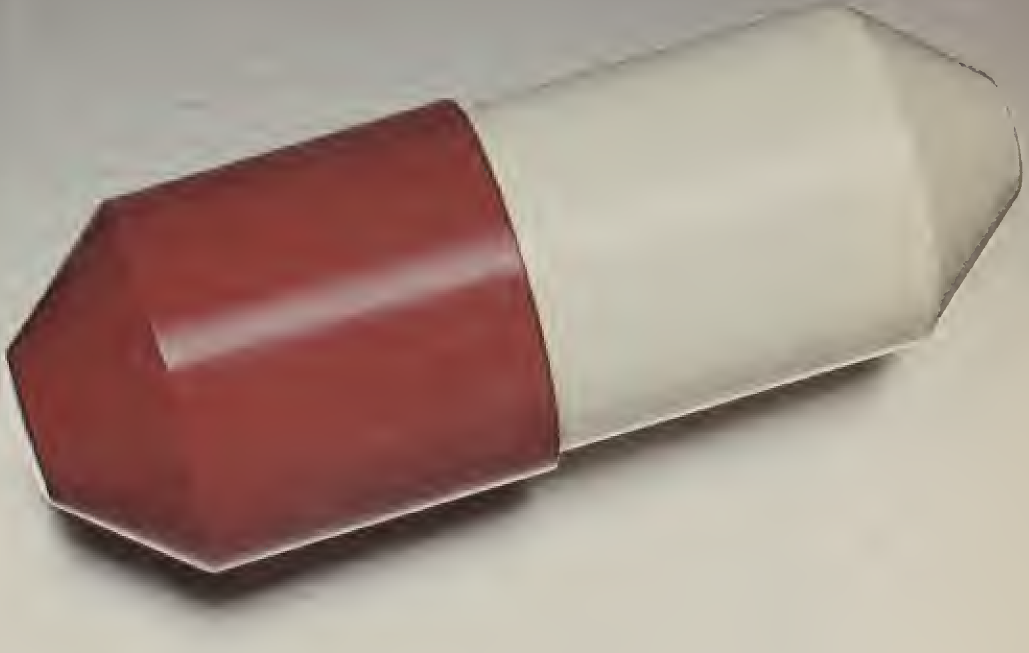
Serum K^+ and BUN should be checked periodically (see Warnings and Precautions)



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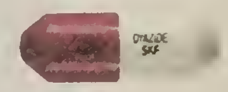

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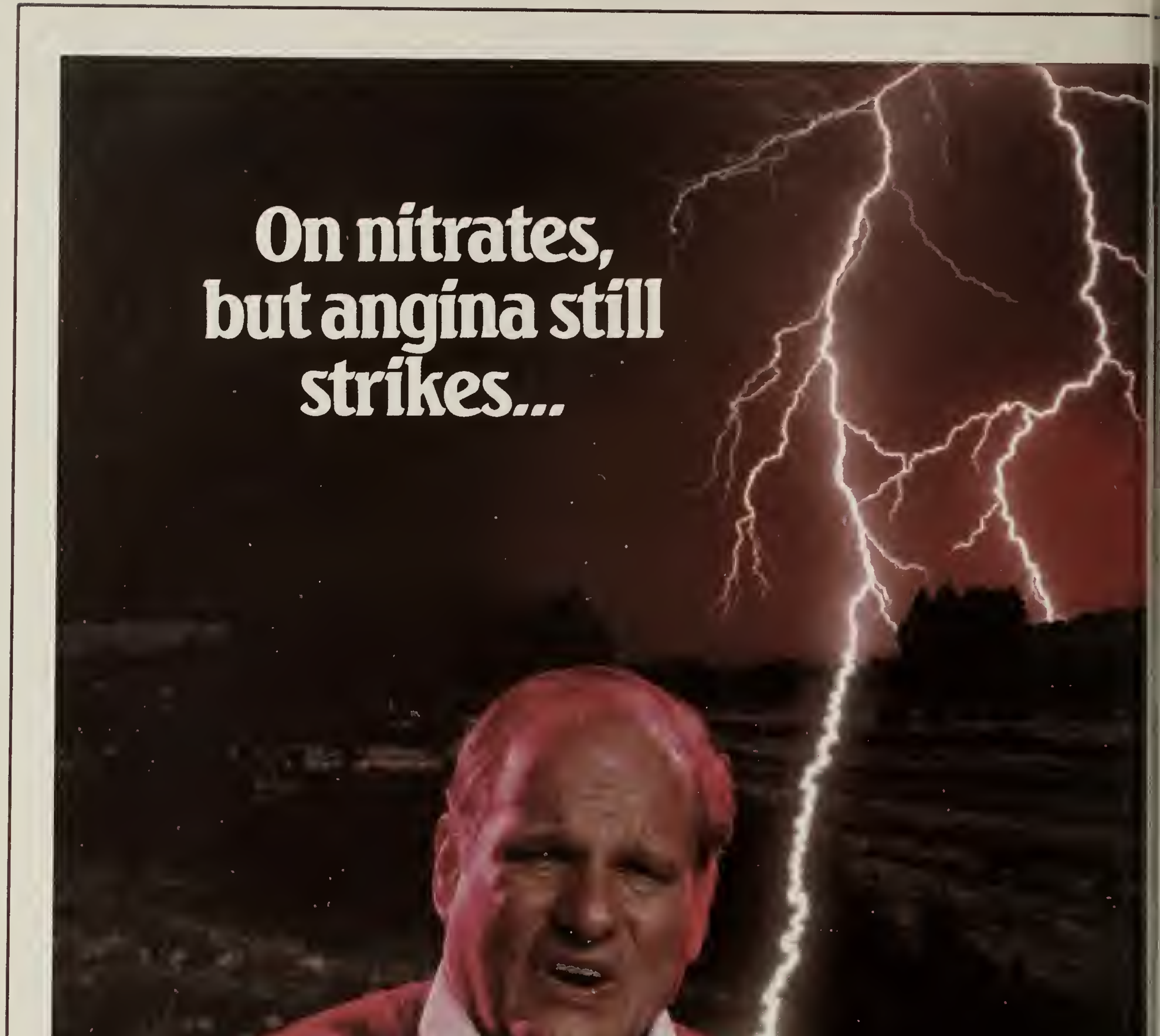
On nitrates,
but angina still
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After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

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With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®

(verapamil HCl/Knoll)

80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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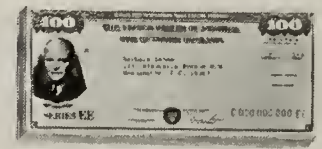

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CARDIZEM
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page. 2/84

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

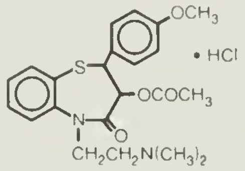
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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Inkster 48141

Richard A. Woodbury, MD — IM
3537 W. Front St.
Traverse City 49684

Joshua Wynne, MD — CD/IM
3990 John R.
Detroit 48201

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

October 17-19 — AMA National Medical Staff Conference, Sheraton Washington Hotel, Washington, DC, contact: Karen Prupes (312)645-4418.

October 22 —"Onward to Lansing" Professional Liability Rally, Lansing, contact: Tom White, MSMS headquarters (517)337-1351.

October 24-26 — AMA Third Annual Conference on Stress, Impairment and the Resident, Harrison Conference Center, Lake Bluff, IL, contact: Karen Prupes, AMA, 535 North Dearborn Street, Chicago, IL 60610.

October 30 — MSMS Practice Management Seminar, Amway Grand Plaza, Grand Rapids, contact: Donna Farougi, MSMS headquarters (517)337-1351.

October 31-November 1 — AMA National Communications Workshop, Westin O'Hare Hotel, Chicago, contact: AMA Divison of Communications, 535 North Dearborn Street, Chicago, Illinois 60610.

November 12-14 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters (517)337-1351.

November 12-13 — Health Policy and Quality of Care for Older Americans, sponsored by the AMA, American Hospital Association and the American Association of Retired Persons, Radisson Mark Plaza Hotel, Alexandria, Virginia, contact: Pat Clark (312)645-4497.

November 20 — MSMS Practice Management Seminar, Stouffer's of Battle Creek, contact: Donna Farougi, MSMS headquarters (517)337-1351.

November 21 — MSMS Leadership Conference, Clarion Hotel & Convention Center (Long's), Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351. **CANCELLED.**

December 4 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

January 22, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 19, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

May 2-3, 1986 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: Richard Campau (517)337-1351.

July 17-20, 1986 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

OTHER MEETINGS

October 24 — Women's Health Day, "Be the Best You Can Be," Dearborn Hyatt Regency, contact: Karen Toupin, Department of Community Health and Health Education, Oakwood Hospital (313)593-7205.

October 28-29 — Retooling the Health Care Industry, Millender Center - Omni International Hotel, Detroit, contact: Michigan Assocation of Health Systems Agencies, 1200 Book Building, Detroit 48226-1843 (313)964-6950 ext. 298.

'Family Health Month'

October has been designated "Family Health Month" by the 55,000-member American Academy of Family Physicians (AAFP). All over the country family doctors are encouraging people to take a close look at their families' eating habits, physical fitness, mental health and possible hazards in the home. Americans are being urged to establish a "partnership for health" with a family doctor because he or she can provide total health care on a continuing basis.

Hospital tests new treatment approach for relapse drinkers

Brighton Hospital, long known for its innovative work in treating alcoholism and related chemical dependency, is testing a program to meet the special needs of alcoholics who resume their drinking after an initial treatment for the disease.

According to Russell F. Smith, MD, the hospital's Director of Education and Research and Senior Medical Advisor, alcoholism is a chronic disease that requires major changes in a person's lifestyle. Patients who relapse and begin drinking again need a different treatment approach, as do patients who experience relapses from such other chronic conditions as cancer, diabetes, and heart disease, says Smith.

An intensive program that includes additional group therapy and education activities has been designed especially for relapse patients. Family members or loved ones are required to participate in several parts of the program.

Additional information on this pilot program can be obtained by contacting Brighton Hospital at (313)227-1211.

Reye's Syndrome update

Thirteen cases of Reye's Syndrome were reported to the Michigan Department of Public Health (MDPH) from October 1, 1984 to August 8, 1985. Ten of these cases have been verified by chart review, as satisfying the Centers for Disease Control definition of Reye's Syndrome. One reported case was finally diagnosed with acetyl co-enzyme A deficiency and therefore excluded as a case. Another reported case had no evidence of fatty liver on autopsy nor elevated liver enzymes. The third reported case which did not fit the CDC case definition had no evidence of liver enzymes greater than three times the upper limit of normal. Three of the thirteen cases died.

Continued on page 572

Is your pension plan working as hard as you are?

Retirement Plan Consulting Services are available through **William C. Halbert and Gerald J. LeVan,** Vice Presidents with E.F. Hutton & Company. See them regarding Pension, Profit Sharing, and Keogh Plans, as well as IRA Rollovers, at the

MSMS 120th Annual Scientific Conference, Booth #221.

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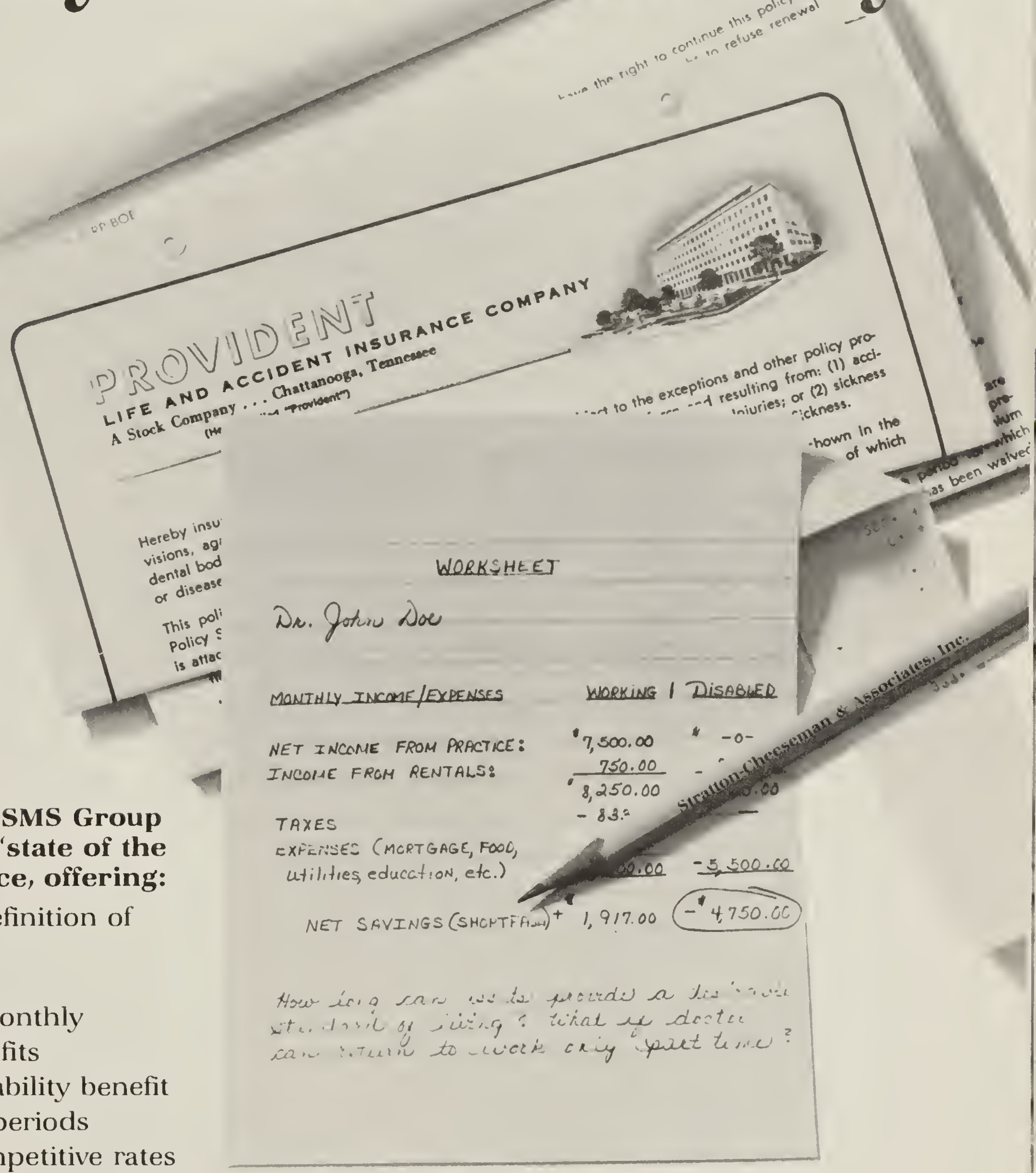

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	$8,250.00	[illegible].00
TAXES	- 83[illegible]	
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.)	[illegible]0.00	-5,500.00
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During the past three years, the Division of Disease Surveillance has conducted a case-control study of school-aged children in Michigan who were diagnosed with Reye's Syndrome. The emphasis of the study was to determine the risk of Reye's Syndrome associated with medication use. Since a sufficient number of cases and controls have been enrolled, we will no longer seek study subjects. MDPH encourages Reye's Syndrome reporting coordinators to continue to report cases by phone per the current reporting system. The department hopes to complete preliminary analysis of our data this fall.

Volunteers needed for menopausal flushing studies

Female subjects are being sought for two research projects at the Lafayette Clinic in which menopausal flushing (hot flashes) is being studied and treatment regimen perfected.

In previous investigations, researchers Leonard Germaine, PhD, and Robert Freedman, PhD developed a hot flash provocation technique, and a promising non-drug treatment. Currently, they are attempting to gain further understanding of the symptoms of hot flashes and further perfect a behavioral analog to pharmaceutical treatment of the disorder.

In a related study, the same researchers are cooperating with Abbott Laboratories to determine the lowest effective dose of an estrogen treatment for menopausal flushing. High levels of estrogen, the traditional treatment for the disorder, have been associated with increased risk of cancer among women beyond menopausal years.

Women volunteers for the study must be menopausal, free of drugs for the course of the study, and in good general health. All volunteers will be compensated with a cash payment at the end of the study. In addition, volunteers will receive free treatment during the course of the study as well as a complete physical, including mammogram, urinalysis and blood chemistry.

For information, call Leonard Germaine, MD, at the Lafayette Clinic between the hours of 9AM and 4PM, (313)256-9521.

New human genetic markers

Major advances in RFLPs technology were reported recently at the eighth Human Gene Mapping Workshop in Helsinki.

Collaborative Research, Inc. scientists found 500 polymorphisms — more than doubling the previous number ever reported. Twenty-nine of these 500 are among the most polymorphic human markers known and will significantly facilitate tracing the inheritance of certain chromosomes in families. The new highly informative probes represent major findings that move science much closer to a goal of pioneering significance: a comprehensive map of the entire human genome.

Such a map could offer science the capability of diagnosing literallly thousands of inherited diseases, including some forms of cancer, heart disease and diabetes. A genomic map would open new vistas of understanding about the inheritance of every human trait.

The scientists assembled a panel of 14 DNA probes that now give medical science the tools for rapid and 99 percent accurate diagnosis and follow-up in bone marrow transplantation procedures. This application of RFLPs will assist medical science in following the course of engraftment, and will provide more and earlier information than current tissue-typing methods. The RFLPs advances also could be used to reduce the uncertainty in current methods of paternity testing.

Fertility regulator

Researchers at the University Southern California School of Medicine have identified a previously unknown substance in male and female reproductive organs, a protein hormone that regulates fertility.

High levels of follicular regulatory protein, or FRP, suppress fertility, and low levels increase it, according to Gere diZerega, MD, who heads the research effort.

The research started six years ago when diZerega attempted to explain why women ovulate only one egg each menstrual cycle. "FRP appears to inhibit the ability of the other (39) follicles to make estrogen. As a result, the follicles don't mature to ovulation," he says.

In one experiment, male dogs injected with FRP (extracted from pig ovaries) stopped producing sperm. diZerega concluded that the FRP blocked the estrogen necessary for spermatogenesis.

"FRP may have possibilities as a male contraceptive," he says. "No drug is currently available in the United States that can inhibit sperm production." FRP birth control therapy in women, diZerega says, is likely to prevent any egg from reaching the ovulation stage.

The discovery of FRP not only raises new possibilities for birth control but also for increasing sperm production in men. "If FRP suppresses fertility, then it follows that antibodies blocking FRP would enhance it," diZerega says.

Another potential application of the FRP discovery would be to slow the aging process in women by slowing the rate at which they lose follicles. "If we moderately increase a woman's FRP levels, thus inhibiting the maturation of follicles, we might reduce the rate of egg loss and extend the reproductive life span." ☐

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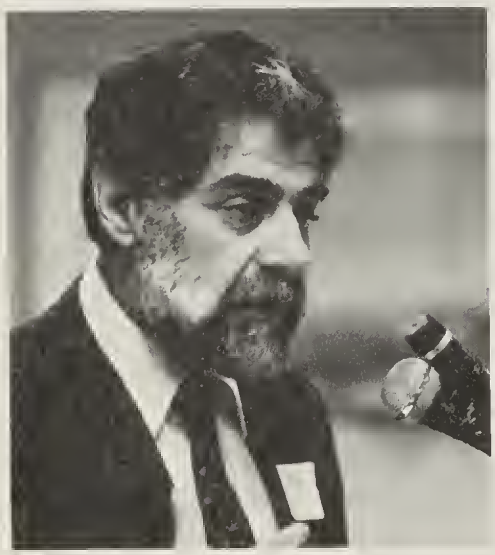
By Louis R. Zako, MD

Malpractice reform for whom?



Doctor Zako

As the immediate past president of MSMS and the chairman of our Task Force on Professional Liability, I should be working my tail off to provide our 11,000 members with relief from the malpractice crisis. Certainly, with the small but growing number of our members declaring bankruptcy, moving out of state, curtailing their practices or retiring early, no one could fault me and the other members of your Task Force for devoting our ideas, resources, and energies to achieving meaningful legislative tort reform as a significant membership benefit.

I must confess, however, that we are not exerting our efforts in that direction. What we are working on is legislative tort reform to *preserve the availability of appropriate medical care for all Michigan citizens*, not just the wealthy. As much as the members of your Task Force sympathize with the plight of our obstetrical colleagues, who more and more are being forced to give up many of the skills they have devoted their professional careers to develop and refine, we are even more concerned with the plight of the indigent woman with a high-risk pregnancy who lives in Wayne County, in Muskegon County, or for that matter in Luce County.

Beyond discomfort

There is little doubt among community leaders that the people of Michigan are now facing a crisis in medical and health care the dimensions of which extend far beyond the discomfort or anguish of individual physicians or certain "high-risk" specialties.

Some members of the news media and of the legislature are predisposed to describe the crisis as simply an "insurance problem." Others see it as an interesting and perhaps entertaining struggle between the medical profession and the plaintiff's bar.

There also are those who say that the increasing number of medical malpractice suits filed and the dramatically increasing size of awards are simply indicative of the amount of negligent medical care being rendered. And they say that physicians are not and should not be special or privileged members of society, immune from responsibility for their negligent acts. Perhaps.

My view is that public awareness and public concern have gone beyond such simplistic conclusions. There is a growing groundswell to preserve our system of medical care without regard to the subjective and biased views of physicians or of plaintiff's attorneys. Legislators who hear the growing chorus demanding relief and label it the whining of an indulged group do so at their own risk.

We are no longer debating the future of the neurosurgeon practicing in the Detroit Medical Center or the orthopedic resident pondering whether to practice in Michigan or in North Carolina. What we are debating is whether the prisoner in the Macomb County jail with a serious illness will receive proper attention and whether the pregnant teenager in the Thumb will have access to appropriate obstetrical services. Not only is the availability and affordability of medical care for the disadvantaged threatened, but this blight is now beginning to spread to the vast middle class. What is the future of medical care in Michigan for the autoworker, the farmer, the person who joins an HMO or PPO?

Relief

No, I am not working on a new MSMS membership benefit—relief from the malpractice crisis. What I am working on, and what I respectfully submit, we should all be working on, is relief for all of our patients. I shall be with you in Lansing on October 22, not pleading for relief for myself or my colleagues, but for thoughtful and concerned legislative attention to the expectations of our 9.5 million citizens that they can continue to receive and afford excellent medical care. Less than that would be a political sham and a sad commentery on us as a family of men and women. ☐

Doctor Zako, Dearborn Heights, is chairman of the MSMS Task Force on Professional Liability, and MSMS immediate past president.

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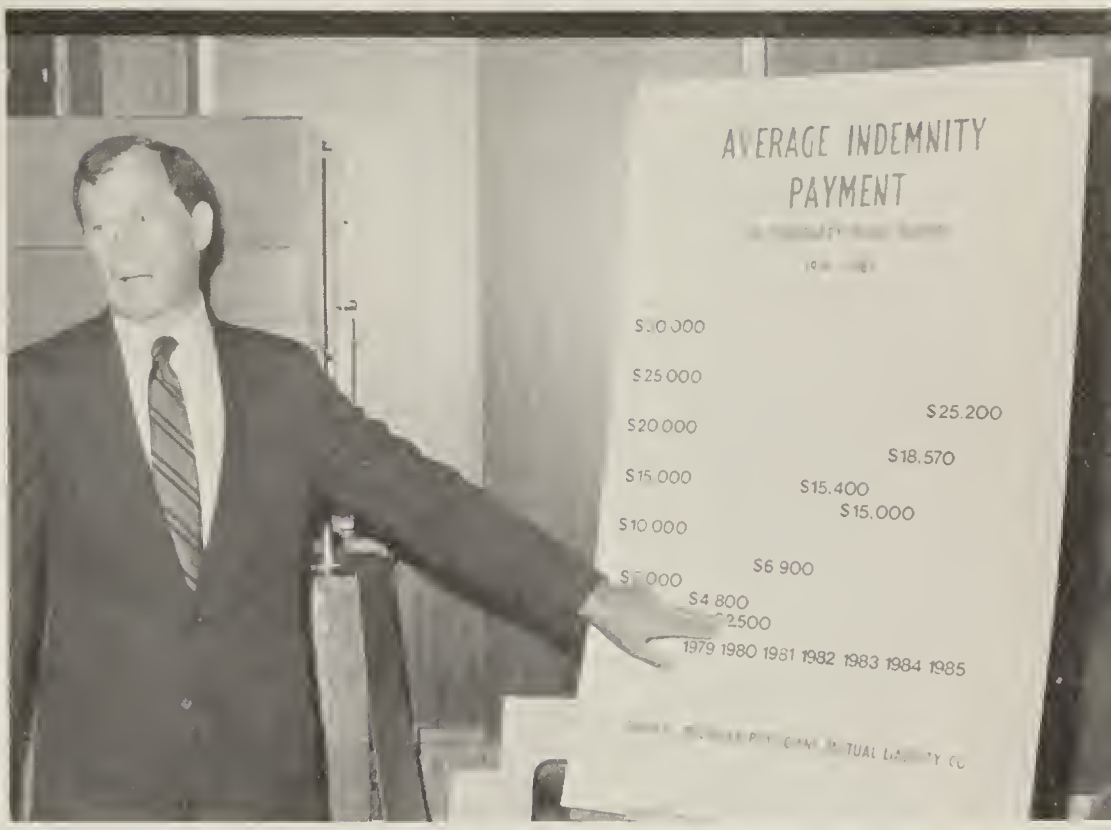
John Dodge, legal counsel for Physician's Insurance Company of Michigan (PICOM) points to escalating malpractice suit filings in the Detroit area from 1970 to the present.

From left to right, Senator Ruday Nichols (R-Pontiac), Sen. Alan Cropsey (R-DeWitt), and Fred Hall, Senate Majority Counsel were among those who heard testimony at the August 27 hearing in Pontiac.

Dan Murphy, Oakland County Executive, testified as to how the professional liability crisis is affecting the citizens of that area.

The media were out in force, and reported extensively on the crowded hearing.

Senate Judiciary public hearing on medical professional liability, August 27, 1985, Pontiac, Michigan.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$20 000
$15 000
$10 000
$5 000
$25.200
$18.570
$15.400
$15.000
$6 900
$4 800
$2500
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Frederick Minkow, MD, told the lawmakers, "The present tort system has become too expensive and cumbersome for the effective delivery of medical care in Michigan." He pointed to the skyrocketing averages for indemnity payments.

Michigan Hospital Association President Spencer Johnson spoke to the audience and lawmakers about the impact on hospitals, hospital care and hospital staff members.

The hearing attracted thought-leaders from around the state. From left to right, Sr. Xavier Ballance, DC, President of Providence Hospital, Southfield; Judge Alice Gilbert; Charles Sempere, MD, Pontiac; Kevin Cole, Risk Manager, Sparrow Hospital, Lansing.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: October 18-19, A Practical Approach to Arthritis for Physicians. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center & Bronson Methodist Hospital. **Contact:** Chris Pearson, Southwestern Michigan Area Health Ed. Center, 1521 Gull Rd., Kalamazoo (616)383-6360. **Approved for:** 6 hours of Category I Credit.

Date: October 19, Common Problems with Coronary Artery Disease. Location: Somerset Inn, Troy. **Sponsor:** American Heart Association. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, 16310 W. 12 Mile Road, PO Box 160, Lathrup Village, MI 48076 (313)557-9500. **Approved for:** 7 hours of Category I Credit.

Date: October 21, A Conference on the Late Effects of Polio. Location: Sheraton Inn, Lansing. **Sponsors:** Michigan Department of Public Health, Coalition on the Late Effects of Polio, Michigan Hospital Association and others. **Contact:** Norman Hayner, MD, Bureau of Laboratory and Epidemiology Services, MDPH, PO Box 30035, Lansing 48909 (517) 373-1396. Approved for: 4 hours of Category I Credit. Also approved for 5 AAFP prescribed credit hours.

Date: October 21-25, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: October 23, The Second Annual Conference on Alcholism. Location: Gilmore HEC Bronson Methodist Hospital. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo. **Approved for:** 6 hours of Category I Credit.

Date: October 23, Update on GYN-Oncology. Location: St. John Hospital,De-

Continued on page 580

STAFF PHYSICIAN

Eastern Michigan University's Ambulatory Health Care Facility is seeking a primary care M.D. interested in developing innovative health care programs at our ideal southeastern Michigan location.

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November 8, 1985
"Management of Cardiovascular Disease: New Frontiers"
Harold Halbrook, M.D.
Fred Morady, M.D.
Norman Shumway, M.D.
Luis Tomatis, M.D.

Contact: Patricia Marks
Symposium Coordinator
Butterworth Hospital
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Grand Rapids, MI 49503
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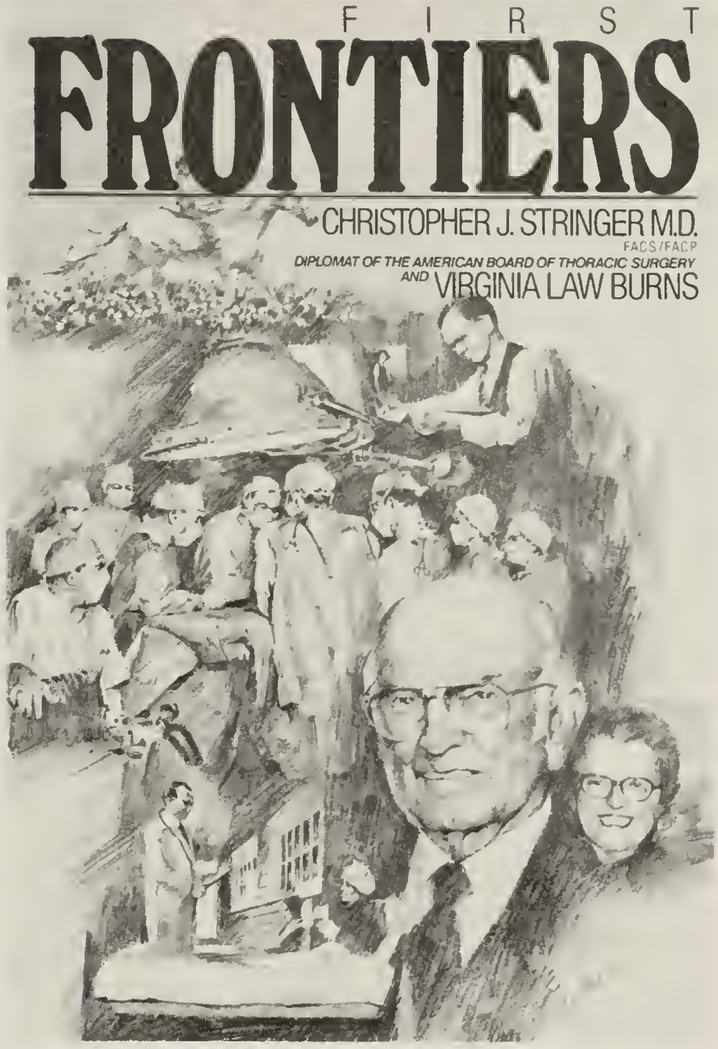
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City ____________________ State ______________ Zip ____________ troit. **Sponsor:** St. John Hospital. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 25-27, Chest Radiology: Pioneers and New Frontiers. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School Department of Radiology and Department of Post Graduate Medicine and Health Professions Education. **Contact:** Dove Margenau, Towsley Center-Box 057, The University of Michigan Medical School, Ann Arbor 48109 (313)763-1400 **Approved for:** 14.25 hours of Category I Credit.

Date: October 26, Update on Infectious Diseases. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 4 hours of Category I Credit.

Date: October 28-29, Laser Medicine & Surgery: The Aerodigestive Tract. Location: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School and Department of Anesthesiology. **Contact:** Betty Phillips, Towsley Center (313)763-1400. **Approved for:** 17.25 hours of Category I Credit.

Date: November 2, Menopause: Practical Aspects of Clinical Care. Location: South Macomb Hospital Auditorium. **Sponsor:** Detroit-Macomb Hospital Corporation. **Contact:** Department of Medical Affairs, Detroit-Macomb Hospital Corporation, 7815 E. Jefferson Avenue, Detroit 48214 (313)821-6000, ext. 270. **Approved for:** 7 hours of Category I Credit.

Date: November 2, Women: Current Psychoanalytic Views. Location: Hyatt Regency, Dearborn. **Contact:** Michigan Psychoanalytic Clinic 16310 West Twelve Mile Road, Suite 204, Southfield 48075. (313)557-8633. **Approved for:** 6 hours of Category I Credit.

Date: November 6, Colorectal Cancer: Essentials for the Primary Care Physician. Location: Gilmore Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** American Cancer Society; Kalamazoo Community Hospitals Oncology Program; and Southwestern Michigan Area Health Education Center. **Contact:** Chris Pearson, SMAHEC, 4th Floor, Stryker Center, 1521 Gull Rd., Kalamazoo 49008 (616)388-7877. **Approved for:** 5.45 hours of Category I Credit.

Date: November 6, 25th Annual Thyroid Workshop. Location: Scott Hall, Wayne State University. **Sponsor:** Wayne State University School of Medicine. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 6 hours of Category I Credit.

Date: November 7, Michigan Family Practice Research Day IX. Location: Michigan State University. **Sponso** Michigan State Family Practice. **Contact** Douglas B. McKeag, MD, Chairman, B 100 Clinical Center, MSU, East Lansin 48824. (517)353-0770. **Approved fo** 10 hours of Category I Credit.

Date: November 7-9, ACLS - Advance Cardiac Life Support. Location: Genvie U. & Donald S. Gilmore Center for Healt Education, Kalamazoo. **Sponsors:** Bronson Hospital Life Support Office & Southwestern Michigan Area Health Educatio Center. **Cost:** $250. **Contact:** Cynd Kochevar Bouma, Bronson Methodis Hospital, Life Support Office, 252 Lovell, Kalamazoo 49007 (616)383 7576. **Approved for:** 20 hours of Category I Credit.

Date: November 7-8, Recognition an Management of the Asphyxiated Newborn. Location: Towsley Center, Anr Arbor. **Sponsor:** Department of Pediatric and Communicable Diseases. **Contact** Betty Phillips, Towsley Center Box 057 Ann Arbor, MI 48909 (313)763-140 **Approved for:**14 hours of Category Credit.

Date: November 8-9, 32nd Annual Detroit Trauma Symposium. Location Harper Hospital. **Sponsor:** Wayne Stat University School of Medicine. **Contact** Theresa Sokol, WSU, Dept. or Surgery, 6- UHC, 4201 St. Antoine, Detroit 4820 (313)577-5009. **Approved for:** 9.5 hour of Category I Credit.

Date: November 12-14, 1985 Annua

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Scientific Meeting, "From Here to Eternity." Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 18 hours of Category Credit.

Date: November 13-14, Advances in Pediatric Hematology/Oncology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 15-16, Making Babies - Can We Do It Better? Location: Scott Hall, Wayne State University. **Sponsor:** Wayne State University School of Medicine. **Contact:** WSU Division of Continuing Medical Education, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 11 hours of Category I Credit.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 20, A Clinical Day on Alcoholism. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital, CME Committee. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 Category I Credits.

Date: November 21-22, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School, Dept. of Postgraduate Medicine and Health Professions Education and Dept. of Otolaryngology-Head & Neck Surgery. **Contact:** Jolene Glaspie, Towsley Center, Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 16.5 hours of Category I Credit.

Date: November 23-25, Tutorial on Fundamental Principles of Manual Medicine as Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: December 2-6, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: February 12, 1986, Pediatric Neurology. Location: St.John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: February 26, (plus five once-a-week sessions March 5,12,19,26,) Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-6502. **Approved for:** 3 hours of Category I Credit.

Date: March 12, 1986, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: April 7-9, 1986, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, 1986, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 16, 1986, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

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THE GENERAL MEDICINE DIVISION OF HENRY FORD HOSPITAL is seeking a seasoned, innovative, General Internist to assume the leadership position for executive medical programs. Interested persons should contact Wilmer M. Rutt, MD, Associate Chairman, Department of Medicine, Henry Ford Hospital, 2799 W. Grand Boulevard, Detroit 48202. Telephone: (313)876-2274.

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A time for testing

Standing at the site of that historic battle in Gettysburg more than 100 years ago, Abraham Lincoln stated that this nation was "dedicated to the proposition that all men were created equal" and that this terrible civil war was a test as to whether "this nation or any nation so conceived and so dedicated could long endure." In the history of all nations, such times of testing occur and great bastions of strength have succumbed to the test of time. History is replete with such cases. Examples include the fall of the Egyptian Pharaohs, the Golden Age of Greece and the Roman Empire in more ancient times and the Third Reich and, to some extent, the British Empire in modern times.

Such testing involves not only governments but more frequently, institutions and customs. Slavery had to come to an end because of its inherent immorality. It could not stand the scrutiny of a civilized society so it failed the test of time.

The Golden Age

During the past half century, medicine has grown in ideas, technology, and success. We are really in the "Golden Age of Medicine" and we should be proud. We need not apologize because we have learned how to keep people alive without a single kidney until a transplant can be performed. At the same time, other transplants are becoming more and more feasible and increasingly successful. They are too numerous to count but they extend from cornea and heart to liver, bone, bone marrow, pancreas, lung, and no one can predict where it will stop. We are increasing longevity while saving newborns, previously not salvageable, at the other end of life. Because the cost is high should we be ashamed? The scientist must never surrender the search for knowledge, but it is a societal decision as to what society can afford.

During this period, while medicine has thrived scientifically, the tort system in the United States has taken an ugly turn. The right to seek redress for wrongs through the courts is a precious right we must not surrender. The framers of our Constitution and the Bill of Rights, however, could never have guessed how that right would be interpreted in 1985. The meaning of the word *liability* has become so distorted that not only physicians and hospitals, but governmental agencies, manufacturers, clergy, teachers, day care centers, country clubs, restaurants and bars, and even lawyers and members of the Michigan Supreme Court need to examine the escalating costs they face.

At this time in history, we confront a critical time of testing in this great nation. One leg of our three part governmental system is the judiciary. If there are concerns about its effectiveness and fairness, we must look carefully at the problems and seek reform. I suspect that a scientific poll of the members of the learned legal profession would agree that we may be going awry. Even the Chief Justice of the US Supreme Court has become critical of the turn of events.

Working together

We physicians need to work together as we have never done before. We are an independent lot but whatever differences we may have we need to sublimate for the good of society — the pu lic, not the medical. We must not be diverted by the argument that there are bad doctors out there. Of course there are, and we would like to have them out of our profession. We will continue to work for a stronger Board of Medicine with some additional powers to regulate them. Does the public know that even the members of the Board face litigation for their efforts to protect the public and that they serve without reimbursement?

Whatever else is true, it is certainly true that fine, dedicated, learned physicians are being sued in alarming numbers. Those dealing with the greatest risks and exhibiting the highest skills are more likely to be sued. We are told that we take these suits too personally. Of course we do! They involve our knowledge, our commitment, our concern, but most of all our ethics and our honor.

On October 22, 1985, physicians will rally on the State Capitol steps. It will be an orderly petitioning to our governor, our legislators and the public. We will be satisfied with 3,000 participants but we will be happier with 5,000-6,000. Mark your calendars. Ask your spouses, neighbors, patients, office personnel and your hospital administrators to join us. History is at a point where it is a time for testing. Are you coming? Onward to Lansing!

Doctor Gagliardi, chairman, MSMS Board of Directors, writes this month at the invitation of MSMS President Richard J. McMurray, MD.

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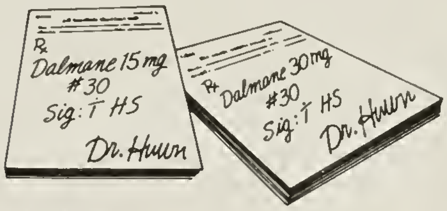

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MICHIGAN MEDICINE

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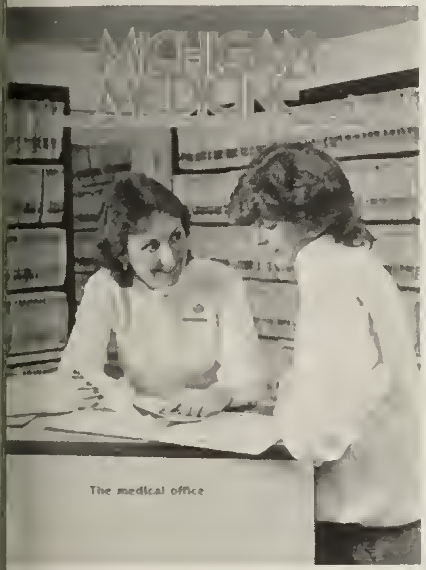
MICHIGAN MEDICINE



About the cover: No business tactic can improve a medical office more than can a pleasant smile.

Special Report

589 Practicing physicians, like it or not, have to wear two hats: one of care-giver and another of business manager. This month's special report features ideas for improving the business side of your practice as detailed in the MSMS "Management and Marketing: Improving Your Practice" seminars held throughout Michigan this fall. Our report offers seminar samplings on office financial policy, telephone tips and appointment scheduling. An additional article suggests ways to improve mailing procedures: Sheri Greenhoe; Sally Scudo.

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In next month's issue of *Michigan Medicine:* The December issue will highlight MSMS membership benefits and leadership, and will feature a special "Onward to Lansing" rally photo section. Watch for it!

By Frederick Bryant, MD

Malpractice revisited

Bryant

Two rudimentary, time-honored traditions of our nation—the rights of free speech and public assembly—have been briskly exercised this season. Physicians (and many others in the health field) are speaking out vigorously on the deleterious effects that legal factors are imposing on the quality, availability and cost of health care in Michigan.

The issue has caught the public eye. Alan Cropsey, Chairman of the Senate Subcommittee on Medical Malpractice, has held hearings over broad portions of the state this summer and fall giving health representatives an opportunity to illustrate and explain adverse aspects of the system as it exists today. As I write, Representative Matthew McNeely, speaker pro tem of the House, and the House Health Insurance Committee are conducting similar studies through the Subcommittee on Medical Malpractice, chaired by Representative Mary Brown. Governor Blanchard promises action and has appointed Robben Fleming, former president of the University of Michigan, as fact finder for the Executive Department. Lieutenant Governor Martha Griffiths has attended hearings and voiced concern.

On October 22 up to half the physicians practicing in the state of Michigan left their offices for a day and assembled at the Capitol to speak personally with legislators, adding emphasis and visible support to our concerns. More than ever before physicians have been seen and heard in public places.

Attention continues to focus on Lansing where a dozen proposals have been introduced in the Legislature or are under consideration. Nevertheless, the legislative process is a complex and tortuous one. Will those who enact, execute, enforce and interpret our laws appreciate the sense of urgency, magnitude and profundity that we see in the enigma?

Never an easy issue, the malpractice crisis surfaced strongly in the mid 1970's, driving medical insurance carriers out of the state and jeopardizing availability of medical liability insurance in Michigan. As forecast then, the crisis has dramatically returned now, in even greater measure than before. But it is more than a sporadic *cause celebre*. Without question it is the single most destructive and vexing force in medicine over the last decade—and is likely to remain so in the foreseeable future. It will not go away: it cries out for action.

Let us hope our lawmakers and executives can agree upon some practical solutions—for it is imperative to the health and well-being of the citizens of Michigan.☐

Doctor Bryant, Royal Oak ophthalmologist, is a member of the MSMS Committee on Publications.

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MDPH clarifies premarital certification requirements

Recently there has been confusion concerning the requirements for premarital certification because of the changes in the law. We have nformed the county clerks of the change, but the distinction between the need to certify freedom from venereal disease and the legal mandates for testing have not been made.

On April 1, 1985, a change n the statutory requirements for premarital testing became effective. The major change that affects the physician is that the law no longer dictates the laboratory tests that are required. This has been misinterpreted by some to mean that testing is no longer to be done or is unnecessary.

The key statement in the statute as it now stands is as follows:

"A county clerk shall not ssue a marriage license to an ndividual who fails to present and file either a certificate setting forth that the individual is free from venereal disease or, f infected, is in a noncommunicable stage and will not endanger the health of the other party to the proposed marriage or the issue of the marriage or a written order waiving the examination requirement. To obtain the certificate, both parties to a proposed marriage, within 30 days before applying for a marriage icense, shall submit to a medical examination by a physician for the presence of venereal disease in a communicable stage. The physician shall conduct and report the results of aboratory tests as prescribed by rules promulgated by the department."

As of now no tests have been prescribed in rules. There may be some exceptions such as elderly couples, where the physician feels he can certify without testing, but it is difficult to see how these requirements can be met in most instances without at least a test for syphilis. The incidence of syphilis is now so low in Michigan that routine premarital syphilis testing is no longer useful as a case finding tool. However, examination is felt to be useful for protection of the persons getting married. In order to help clarify the matter to the County Clerks, the following notice has been sent to them:

"As you were previously notified, the premarital requirements for venereal disease testing were changed effective April 1, 1985. The fact that laboratory tests are not legally required has led to the misunderstanding that testing would no longer be done by the physicians. In fact, the physician is still required to certify that the individual is free from venereal diseases and, in most cases, will need laboratory testing to make that certification.

"If you receive inquiries as to whether laboratory tests will be needed for a marriage license, the proper response is that it is up to the physician whether such tests are needed, and most physicians will want tests. To merely state that tests are no longer required is really not accurate and misleads the public.

"Your cooperation in helping to clarify this situation will be much appreciated by everyone involved."

It is hoped this will clarify the matter for all involved.

Kenneth R. Wilcox, Jr., MD, Chief
MDPH Bureau of Laboratory and
Epidemiological Services

Psychiatric Society petitions State to provide defense

The following letter was sent to Governor James Blanchard in early October.

The events surrounding the case of Ismail B. Sendi, MD, a psychiatrist at the Fairlawn Center, who is part of a lawsuit concerning the death of a child at the hand of a former Fairlawn patient, have made obvious the need for the Michigan Psychiatric Society to make a public statement with regard to the execution of Civil Service rule 1.6.1, which requires that the State, as employer, furnish appropriate defense in the case of lawsuit.

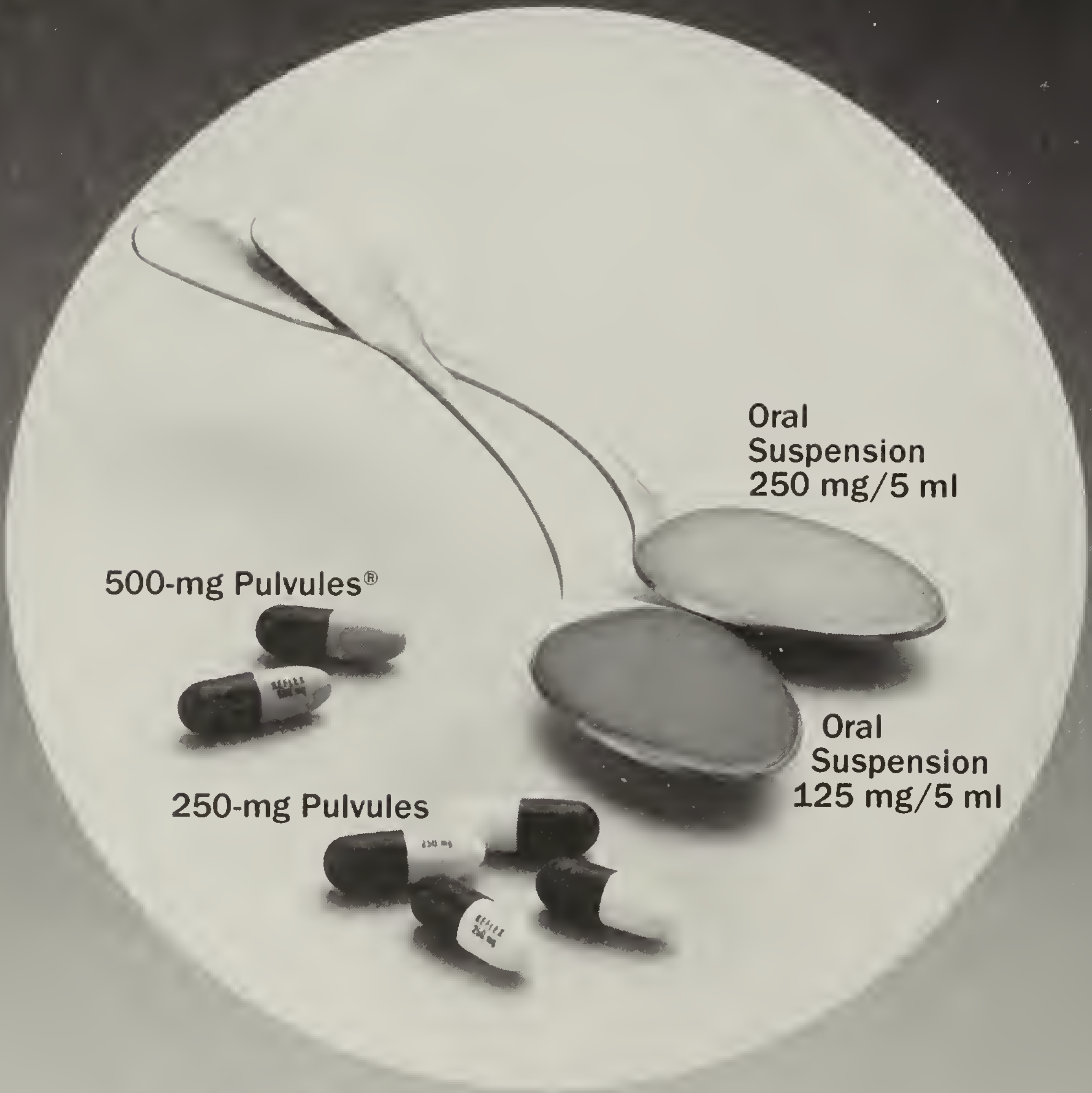
The Michigan Psychiatric Society wishes to go on record in support of the requirement that the State of Michigan fully defend and indemnify its employees in non-criminal cases. We encourage the State to live up to its responsibilities, particularly in the case of Doctor Sendi, and to eliminate the practice of making individual exceptions in cases where the defendant has private insurance (usually clinicians) or cases where an administrator is involved.

It is our hope that you will not only address the individual case involving Doctor Sendi, but also, more importantly, the issues that transcend Doctor Sendi's case, affecting all mental health professionals who worked in the State system.

If I or any of the members of the Michigan Psychiatric Society can be of assistance to you in this matter, please do not hesitate to call upon us.

George F. Newman, MD
President
Michigan Psychiatric Society

Easy To Take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By Sheri W. Greenhoe
Managing Editor

Establish your financial policy before the patient walks in

Don't wait until your patient is leaving your office to talk about payment. That's the advice medical office management experts gave MSMS members this fall during "Management and Marketing: Improving Your Practice" seminars held throughout the state.

Physicians and their office staff members can avoid awkward moments by putting their payment policies on paper ahead of time. Doing so serves two purposes: office employees will know in advance how to handle questions and requests from patients; patients will be able to anticipate payment procedures, and most will appreciate that.

It's a good idea to prepare a patient brochure outlining your fees, billing and collection system. Many patients find money matters difficult to discuss with their physicians. By mentioning a few words about your fee schedule, you can not only ease their apprehension, but open the door to cooperative discussion—perhaps resulting in a reduction of collection headaches. Tell them about your fees, indicating the variance for different procedures such as lab tests.

Do you prefer payment at the time of the visit or will you send a monthly statement? Keep in mind that it is not necessary or desirable to list specific fees for procedures. Do state your policy about overdue bills and the use of collection agencies.

If you will arrange payment plans for large bills, be sure to mention it. You should define "large" either in dollar amounts or terms such as "surgical procedures." Remember that your statements must conform to Regulation Z of the Federal Truth & Lending Act, if advance arrangements are made for more than four payments.

Pay at the time of service

If your policy calls for payment at the time of service, consider employing a few "helps" to facilitate things. Some physicians post signs at

Continued on page 590

their discharge desks, while others instruct their staff to mention payment when phoning to confirm appointments.

One way to remind and encourage patients to pay on their way out is to have them hand carry the invoice, written up in the examining room, to the receptionist (or "cashier").

Having appropriate physical arrangements for payment is convenient for the physician and office staff as well as for the patient. A separate discharge station, away from the admissions window, allows a degree of privacy and more time for discussion. At the discharge desk, the office worker should ask for payment by simply stating the total. This "puts the ball in the patient's court" and usually is effective.

Some medical offices have a private area set aside where the patient and physician or office manager can confidentially discuss special payment arrangements.

Please bill me

Your written financial policy should include procedures for following-up on the patient who leaves without paying. It is a good idea to have the patient leave with an invoice and return envelope in hand.

If that doesn't produce payment, send a second statement in a different type of envelope to get the patient's attention. Some physicians use letterhead rather than the typical window envelope, or use a different color of stationery.

If you still don't receive payment, call your patient. Ask if there is a problem, and when you might expect payment. Studies show that a phone call can be ten times more effective than mailed statements.☐

Suggested components of a financial policy

The following list is intended to stimulate ideas that you can use in developing the components of your financial policy—your internal agreement for management understanding and use.

Once the components are selected, you need to phrase them in a way that suits you for distributing to your patients.

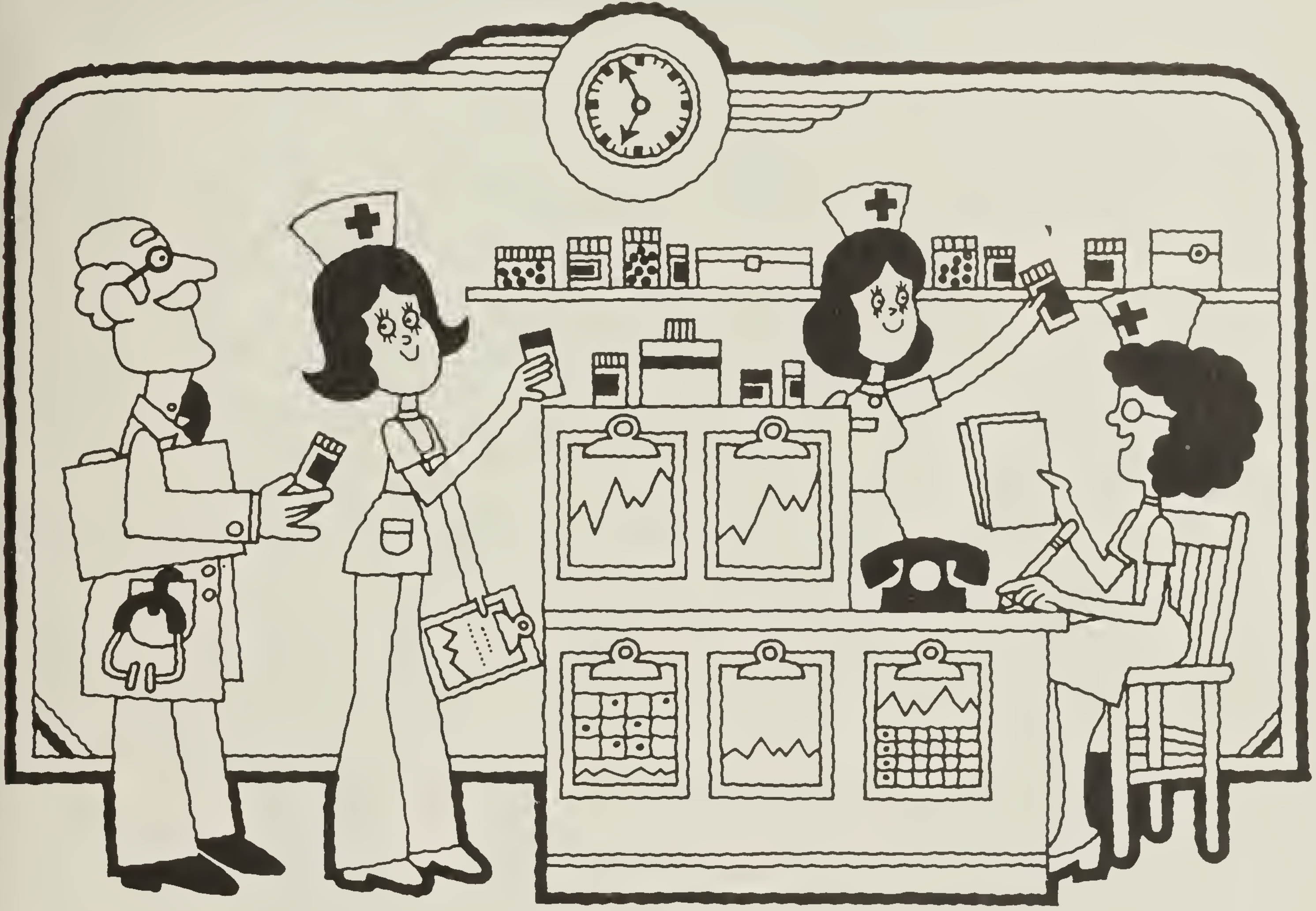
1. Why your policy now is in writing
2. Why we need to update personal information files on each patient every two years
3. Initial office visit—what payment is required
4. Allowable forms of payment; e.g., cash, check, money order, VISA, Mastercard, bank loan plan
5. Broken appointment policy and charge
6. Patient is responsible for total amount of fee
7. Medicare/Medicaid—what policy? Established patients only?
8. Office policy on insurance: assignment or not? Full fee due now or just estimated deductible? Is service fee charged for filling out more than one insurance form and, if so, how much?
9. Maximum number of payments allowed. Do you use promissory notes or Truth in Lending forms?
10. Interest or service charge—rate and when applied; rebilling charge
11. Lab charge retainer fee—due at time of the prep appointment?
12. Specialists/consultants—if required, will bill patient directly?
13. Legal forms, fee, when collected
14. Welcome the opportunity to discuss any aspect of financial policy☐

Ideas for other policies

In addition to the financial components, a written office policy can include any of the other aspects of your practice that you want your patients to know and be able to refer to, such as:

1. Office hours
2. House calls
3. Emergencies
4. Number to call for billing questions
5. Conditions treated—specialty
6. Auxiliary staff support—titles, job description, introductions
7. Prescriptions, refills
8. Appointments
9. Map or directions to office☐

Consider these telephone aids



The telephone can be your best friend or your worst enemy. At its best, the phone can be a lifeline during emergencies: at its worst, it can be an annoying source of interruptions.

To improve the telephone situation in your office, employ these aids and techniques:

Busy signal study—the phone company will do this for you for free. The results will show you how many patients—or how few—are greeted by a busy signal when they dial your number.

Touch-tone equipment—it is faster and more compatible with today's new phone systems.

Direct line to and from the hospital—allows you to avoid having to go through a switchboard.

No telephones in exam rooms—interruptions during exams are annoying to you as well as to your patient.

Office beeper—allows your staff to reach you almost anywhere, any time.

No long, unproductive phone calls—just common sense.

Wall phones v. desk phones—having to stand while talking discourages lengthy calls.

Encourage patients to see you at the office: discourage telephone diagnosis—encourage chronic callers to schedule an appointment to see you. Or mention a convenient time of day for them to call with questions.

Use a headset—this keeps hands free for other tasks.

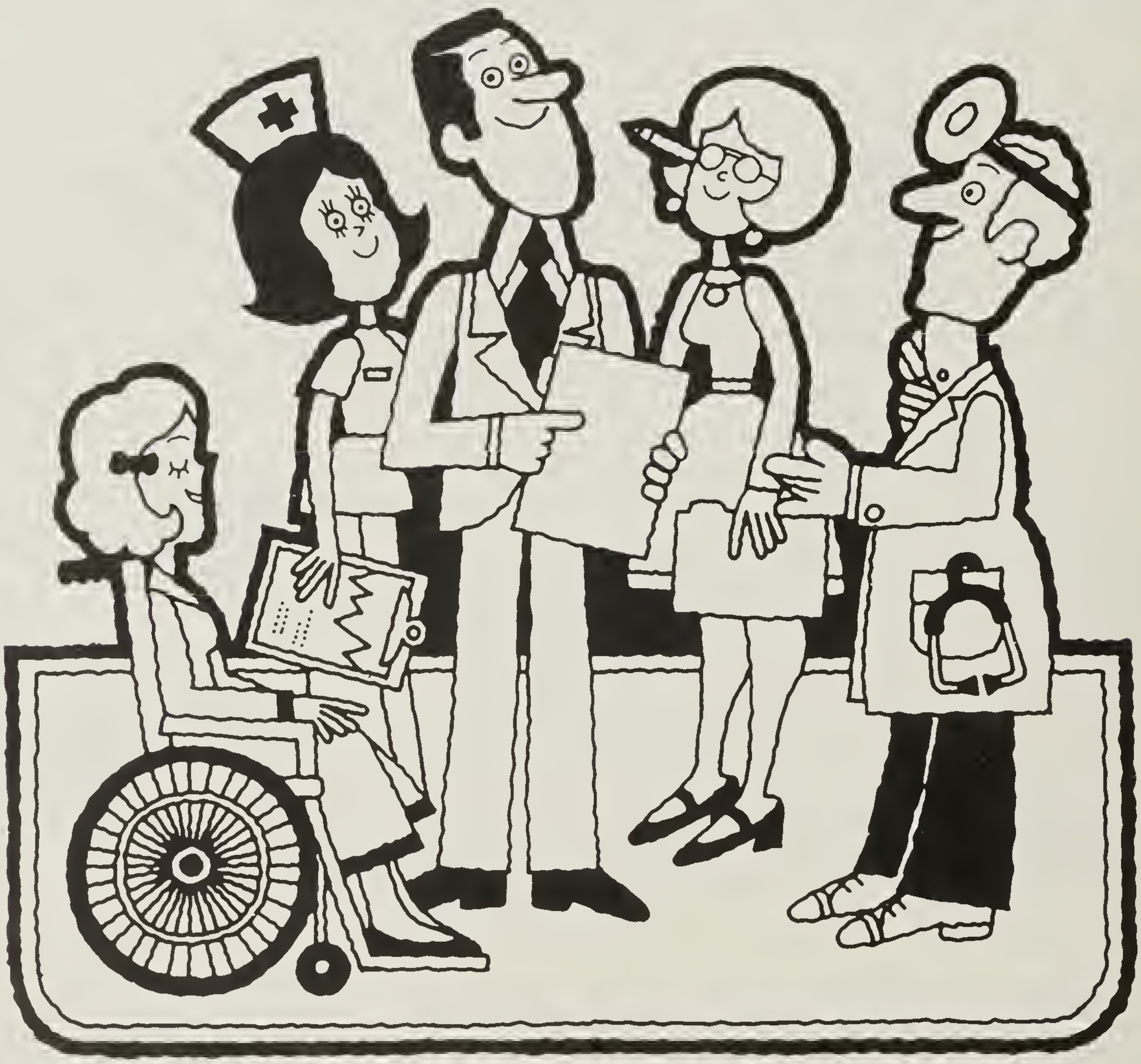
Telephone triage

Instruct your staff to prioritize incoming calls in this order:

1. Emergency patient
2. Urgent patient
3. Routine patient
4. Another physician
5. Pharmacy
6. Hospital
7. Personal
8. Other□

By Sheri W. Greenho
Managing Edito

Appointment scheduling hints



Sticking to your appointment schedule can be difficult, especially on those days when the unexpected happens. These hints can help you anticipate and avoid scheduling problems:

First, keep a daily log of the types of patients you have: walk-ins, noshows, cancellations. This will give you an idea of the make-up of your patient load, and will allow you to tailor your schedule accordingly.

•Don't overbook the first hour—schedule the longest appointment of the day in that slot. That will allow for some flexibility: the appointment can begin without you if you happen to be late. But,

•Don't you be late—unless it is unavoidable!

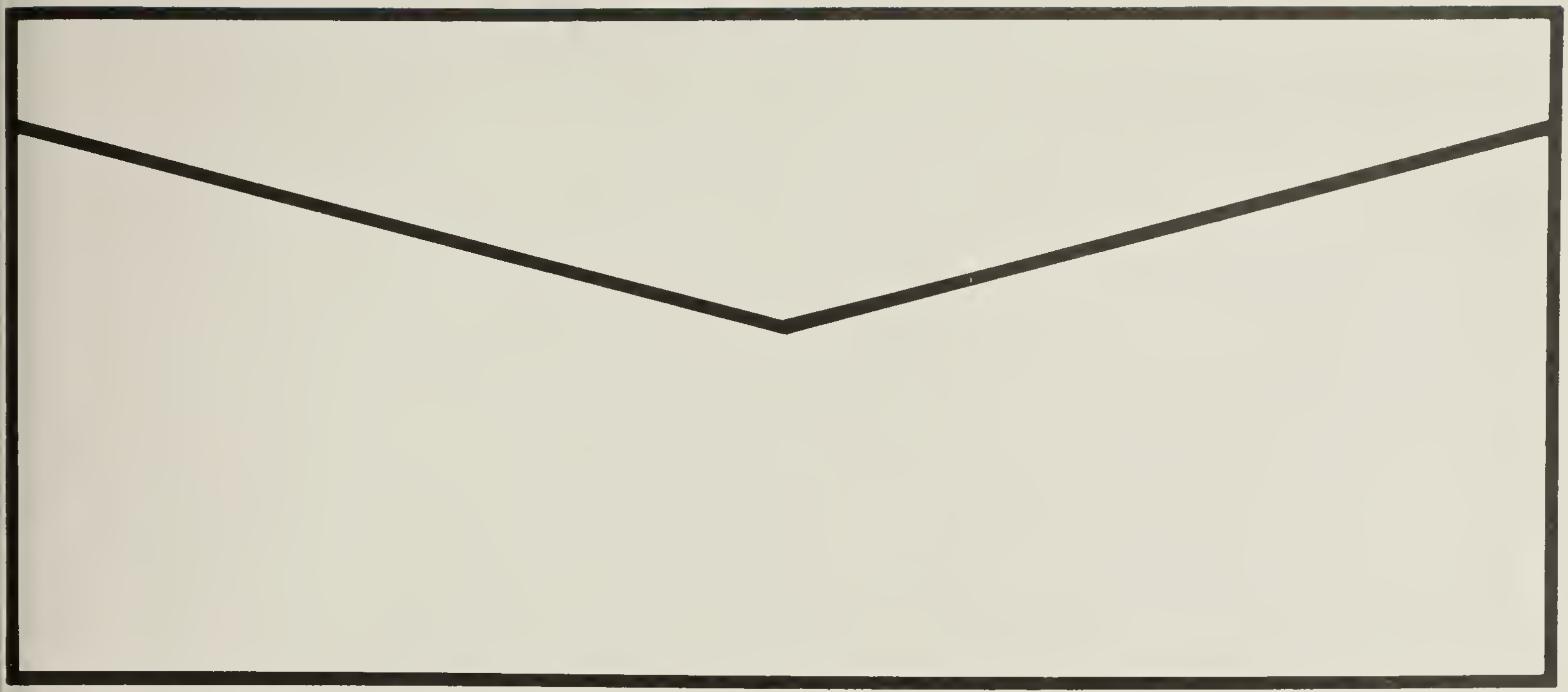
•Don't schedule too far in advance—patients will forget their appointments, and you will have little flexibility.

•Have enough exam rooms.

If you find that you are very behind schedule, tell your patients so and that you will reschedule them later in the day or at another time. Do this before they have waited a long time. They will appreciate your honesty and concern for their own schedules. Patients typically equate "on time" with efficiency, and efficiency with quality.

Reschedule just one block of patients in this manner. That way, you will risk making four patients unhappy, as opposed to making 16 *angry*.

One more tip: Do not tell patients who need follow-up checks (for blood pressure and the like) that they don't need an appointment. When they later show up unannounced your entire schedule could be disrupted. This is especially likely if that "quick check" uncovers a situation that requires immediate care.☐



Rx for better mailing

From a release by Sally Scudo of Pitney Bowes, a mailing equipment company.

With the recent postal rate increase, it's more than a good idea for medical office administrators to take a look at streamlining their mail operations to get the best service for their postal dollars. Robert Pascal of Pitney Bowes has a few suggestions that can help maintain, or even reduce, a medical office's postal budget and let employees spend less time with paperwork and more time with patients.

Good mailing habits

Pascal suggests following these good mail practices to help reduce costs and streamline service:

Make addresses machine-readable—High-speed electronic mail sorters with optical character readers are now installed by the USPS in many large cities. To get your mail "on the fast track" use only capital letters, don't punctuate, use ZIP Codes and the two-letter state abbreviations.

This may be the time to start ordering new envelopes that will make it easier for the electronic "eyes" to read your mail, Pascal says. The glassine in some window envelopes, for example, reflects light and prevents the OCR from reading the address. Colored envelopes also can be a problem. The USPS can test envelopes for you.

Don't forget that to be processed electronically, envelopes must meet certain size requirements. Odd-shaped or under- or over-sized envelopes have to be sorted by hand and there's a 10 cent surcharge for every one, too.

•Combine Mail—While the cost for an initial ounce of first-class mail is higher, the cost of each additional ounce remains 17 cents. Instead of separately mailing a bill and and appointment reminder for a total cost of 44 cents, Combine the two items on one envelope and mail them both for 22 cents.

Few letters weigh a full ounce, so it pays to take advantage of the allotment by mailing two pieces for the price of one.

Doctors find that the convenience of a self-addressed envelope included with each bill can often mean faster payment. With a simple inserter connected to your mailing machine and electronic scale, bills and return envelopes can be automatically stuffed into envelopes, weighed, sealed, stamped and postmarked.

•Use pre-sort and ZIP + 4—If your office often sends mail in batches of at least 250 pieces, you can save nearly one cent per piece in postage by using ZIP + 4, also known as the nine-digit ZIP.

Larger offices and clinics could even qualify for ZIP + 4 and presort discounts if they mail in batches of 500 or more. By presorting to ZIP codes, a mailer can save four

Continued on page 594

MAILING/Continued

cents per piece. Presorting to carrier routes means a five-cent discount per piece. Use of ZIP + 4 adds another half-cent discount per piece. Low cost meter ads can also be used to automatically mark envelopes for presort identification.

- Mail early in the day—By avoiding the five o'clock rush at the post office, when most business mail arrives, your letters are handled faster. In most cases, they can be delivered the next day. Mail deposited by noon stands the best chance for expeditious handling. Pascal notes that faster handling of regular first-class mail can reduce the number of times you have to rely on expensive overnight services. Even the US Postal Service's Express Mail, usually less expensive than private carriers, has been increased to $10.75 for up to two pounds.

But there's even a way to save on Express Mail, he says.

Ask for post office-to-post-office delivery, at $8.60, rather than the better known post-office-to-addressee delivery, which costs $10.75. Although the recipient has to pick up the item at the post office, that can be as early as 10 AM. Compare that to the 3 PM delivery time for post-office-to addressee Express Mail. This is a real money saver if your recipient has a post office box.

Postage meter speeds handling

Using modern mail equipment can cut expenses, too. Both the GP with an office at home and a busy urban clinic can benefit from the advantages of using a postage meter, says Pascal. Even if you send just a few letters or bills each day, a postage meter is well worth the monthly investment (as low as $14) because it saves time—yours and your mail's, he says.

For one thing, a postage meter mailing machine is like having your own personal post office. It enables you to print postage in your office for virtually any kind of mail—from outgoing bills to a pair of eyeglasses or prescription. A real time-saver for busy offices is a postage-by-phone meter that enables the user to reset the machine with a simple, toll-free phone call instead of having to lug the meter to the post office for resetting. This is the most popular mailing system now being sold to both small and large professional offices and businesses, says Pascal.

Exact records

A postage meter keeps an exact accounting of postage used. That information, along with the cancelled checks used to "buy" postage, provide precise records for your accountant at audit time.

Multi-doctor offices or clinics which must bill individual physicians or departments for mailing expenses can easily track these costs with an electronic accounting system (EAS). An EAS tied into a postage meter automatically records both the amount and user of postage.

Correct weight saves dollars

One chief culprit of mail inefficiency is a hard-to-read mailing scale, says Pascal.

"If you don't have an electronic mailing scale, you're probably paying more postage than you have to. Mechanical scales and their charts are often hard to read and if the weight indicator is on the line between one postage price and another, most people go with the higher amount to be safe," he says. With First-Class mail, the extra postage can sometimes be as much as 100 percent, he adds.

"The best thing about electronic scales is that they not only tell what something weighs, but also how much it costs to mail," he says.☐

MEDICARE FREEZE/Continued

claims based on equal protection and violation of the Administrative Procedure Act. —American Medical Association, v. Heckler, 606 F.Supp. 1422 (D.C. Ind., April 18, 1985).☐

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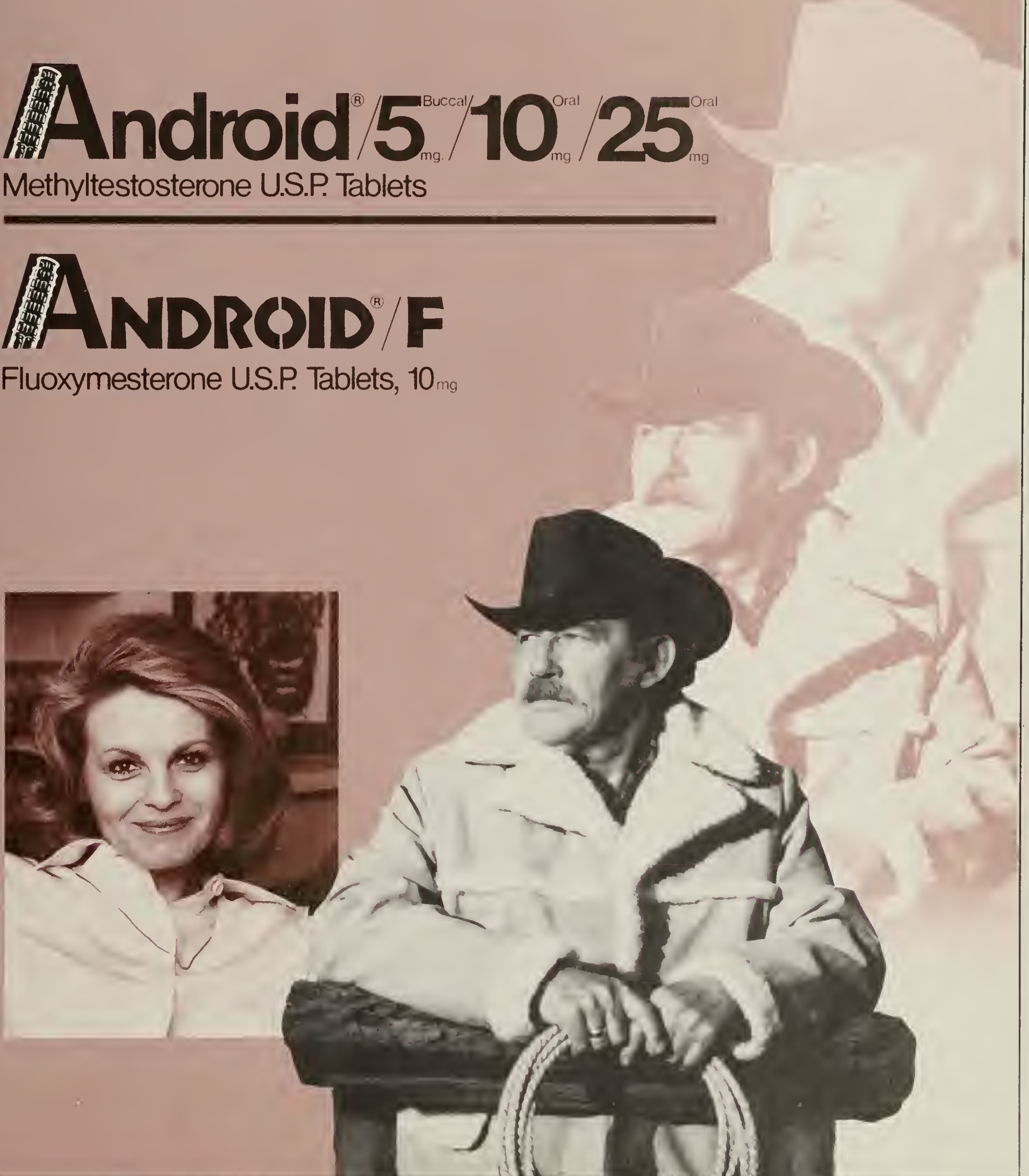

Court rules Medicare freeze not unconstitutional

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Sections of the Deficit Reduction Act freezing amounts that could be charged by physicians to Medicare beneficiaries were not unconstitutional, a federal trial court in Indiana ruled.

Several physicians, patients, the Indiana State Medical Association, and the American Medical Association brought an action challenging the constitutionality of sections of the Deficit Reduction Act. One provision of the Act froze both the prevailing and the customary charge levels for the 15-month period beginning July 1, 1984. Non-participating physicians were limited to charging Medicare patients no more than their actual charges for the calendar quarter beginning on April 1, 1984.

In addition, the Act provided that participating physicians had to accept all Medicare payments by assignment of benefits. Prior to the Act, a physician could either accept assignment of benefits or could charge the patient directly. If the physician chose not to accept assignment, there was no limitation on the amount he could charge a Medicare beneficiary. Under either situation, Medicare would normally pay 80 percent of the reasonable charge, and the Medicare patient would be liable for the balance.

The Act encouraged physicians to become participating physicians by mandating that the Secretary of Health and Human Services publish a directory of participating physicians to be made available to all Medicare beneficiaries and to provide for the electronic receipt of claims from participating physicians enabling them to have their claims processed more quickly.

In a five-count complaint, the physicians and the AMA claimed that the freeze on the amount that non-participating physicians may charge their patients discriminated against them in an arbitrary and irrational fashion in violation of the equal protection provision. The second count claimed that patients would be unable to obtain medically necessary services and treatments from the physicians of their choice, thereby depriving them of their rights of privacy, personal liberty, equal protections, due process, and protection against arbitrary and capricious governmental action. In count three, the Medicare beneficiaries claimed that the government breached its contractual promise that they would receive equivalently calculated reimbursements for physicians' services regardless of their choice.

In count four, certain physicians and the two medical associations claimed that the failure to release information essential to physicians' decisions on whether to become participating physicians caused the October 1, 1984, deadline to be fundamentally unfair and in violation of the Due Process Clause of the Fifth Amendment. Finally, in count five, the physicians and medical associations asserted that a letter defining the phrase "actual charges for the calendar quarter beginning on April 1, 1984" violated the requirements of the Administrative Procedure Act because no prior public notice and opportunity for comment was given.

Dismissing the claims in counts two and three that as a result of the fee freeze, Medicare patients will be unable to obtain medical services from the physicians of their choice. The federal court said that there was no evidence that any of the patients had been denied the services of a physician of his or her choice because the patient was a Medicare patient. They failed to demonstrate that anyone had denied them access to physicians of their choice. Applying the rational relationship test to the other three counts, the trial court said that the fee freeze was rationally related to Congress's reasonable objective of controlling the federal deficit and Medicare costs.

The "Dear Dr." letter sent by the Secretary to the physicians defining the phrase "actual charges for the calendar quarter beginning April 1, 1984" was not a rule or regulation that was subject to the notice and comment provisions of the Administrative Procedure Act. The letter, which interpreted the meaning of the term "actual charges" as used by Congress in the Deficit Reduction Act, may not be the only fair or desirable interpretation of the statue, the court said. However, it was sufficiently reasonable to conform with both the plain language and intent of the Act.

The court entered judgment in favor of the government on the

Continued on page 594

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By Carole Eberl

Blues' school fitness program shapes up Michigan kids

A $262,000 physical fitness and nutrition program to shape up Michigan's children is being sponsored by Blue Cross and Blue Shield of Michigan.

If the program yields the expected results, the Blues hope similar projects will begin nationwide.

"We're hoping for a long term health benefit from this," said Doctor Donald Bearden, the Blues' medical director for alternative health care systems. "This program tends to foster better health through working with the children who, of course, will be adults of tomorrow."

Blues' officials termed the program, which had a pilot run in the Stockbridge elementary school district in 1983-84 a success.

Guy Reiff, of the University of Michigan Fitness Research Center and one of the coordinators of the program, said body fat and blood pressure dropped, while upper body, abdominal strength, trunk flexibility and endurance increased among the K-6 students in the pilot project.

"The Fitness for Youth program is designed to help youngsters understand how exercise and nutrition can benefit them and to provide the information they need to monitor their own physical well being," Reiff said.

"We've documented not only improved physical conditioning, but also changes in the attitudes these young people hold about themselves," he added.

Currently, the school districts of Dexter, Warren-Fitzgerald and Lake Odessa are targeted as new participants in the exercise-nutrition programs. Bearden said plans call for eventual expansion of the program to school districts in the northern and western parts of the state.

"We know that about 40 percent of America's youth have at least one risk factor for heart disease. Research has told us that intervention programs featuring exercise and nutrition counseling will reduce those risks and ultimately help lower medical costs," he said.

Community efforts

The program is a whole community effort which involves teaching children, and also their parents, wellness concepts and good exercise habits. In at least one district, school lunch programs will be modified to cut down on fats and sugars.

"We make children aware of what they are eating," Doctor Bearden said. "In many cases, they take this information home with them and pretty soon the parents are changing their eating habits."

The program focuses on students receiving 30 minutes of aerobic exercises twice each week. Reiff maintains it represents a major change from the usual physical education program.

"I've seen more gyms, more PE teachers, more administrators and talked to more kids than anybody else in this country," he said. "I discovered that in most programs nothing is going on, nothing that is measurable. They grade the kids on deportment, showers and attitude."

The Stockbridge program went over so well that the school system decided to continue the program with its own funds for its 1,200 K-8 students.

Similar programs in Blissfield, Waterford and Romeo also received the Blues' support during the past year.

The hidden question is, what's in it for Blue Cross/Blue Shield?

"One of the major goals of the program is to reduce the risk of heart diseases by motivating youngsters," said Larry Sell, MD, the Blues' vice-president and medical director. "Good nutrition and exercise habits learned now can translate later into less frequent medical care and ultimately lower medical costs."□

Ms. Eberly is a Lansing-area freelance writer.

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Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

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Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "△" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

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By Shirley Prust

National Auxiliary meeting highlights

The American Medical Association Auxiliary Leade ship Conference was held at the Drake Hotel in Chicago October 6-8. About 500 Auxilians from nearl every state attended. Of these, 14 were from Michigan. The three state officers were Cathie L. Martin, president; Shirley F. Prust, president-elect; Pat Allen, vice president. The county president-elects were, Gera Brown, Saginaw County; Sharon Gift, Jackson County; Sharon Helmer, Genessee County; Jean Howard, Grand Traverse County; Peg Kuhn, Wayne County; Karen Maupin, Kent County; Rovilla McGee, Oakland County; Chris Sanden, Muskegon County; Ruth Scott, Ingham County and Marjorie Wardwell, Kalamazoo County.

The activities ranged from a large membership work shop to small sessions on Speaker's Training, County Idea Exchange and State Idea Exchange. Other subject covered were Budgeting and Resources, Community Services for Older Americans, Grassroot Fundraising, Parliamentary Procedure, Coping with the Malpractice Issue, Impairment—The Physician and Family and the Rising Cost of Medical Care. We were privileged to hear three speakers. The keynote speech by James H. Sammons, MD, executive vice president of the AMA was given at the opening dinner. The following morning the breakfast speaker, Francis G. Edwards, senior vice president of Louis A. Allen Associates, Inc., California, gave a stimulating talk on leadership strate gies. The luncheon speaker was D. Harrison L. Rogers, Jr., MD, president of the AMA.

Between activities we were able to view many state exhibits, establish new friendships and exchange ideas

Most of us left the meeting with a personal commitment to promote auxiliary activities. ☐

Mrs. Prust is MSMS/A president-elect.

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U-M Medical Center model facility for spinal cord injuries

The University of Michigan Medical Center has been designated a model spinal injury center by the National Institute for Handicapped Research (NIHR), becoming one of only nine such centers in the nation.

Along with the designation, the U-M Medical Center's Spinal Cord Injury Program, an interdepartmental program of the Department of Physical Medicine and Rehabilitation and the Department of Surgery, was awarded $400,000 for the first year of a five-year NIHR grant to develop and demonstrate innovative rehabilitative care.

"The system of treating people with spinal cord injuries at U-M Hospitals is one of the highest quality health care systems in Michigan," says Theodore M. Cole, MD, professor and chairman of physical medicine and rehabilitation. "U-M Hospitals is one of the few hospitals which attracts and treats people whose paralysis is so high as to require them to use mechanical ventilators to substitute for the body's normal breathing ability."

Doctor Maynard said the Medical Center's Spinal Injury Center plans to develop methods of linking Survival Flight, the U-M Medical Center's emergency helicopter service, with the acute care programs of hospitals in a seven-county area. The Center also will develop a system to study the cost effectiveness of the care delivered.

In addition, the Center will conduct several research projects. One involves developing better therapy for patients suffering spasticity. Another involves testing the theory that the quality of life of patients can be improved by encouraging them to adopt a philosophy of independent living soon after their injuries.

Yet another research project will involve studying bladder problems frequently associated with spinal injuries to develop ways of preventing kidney and bladder complications. "In this project," Doctor Maynard said, "we will study the effectiveness of various therapies and attempt to identify optimum management methods that will lead to improved results."

Hearing-impaired benefit from new listening center

Harper Hospital's new Assistive Listening Device Center opened in mid-September to show

Continued on page 610

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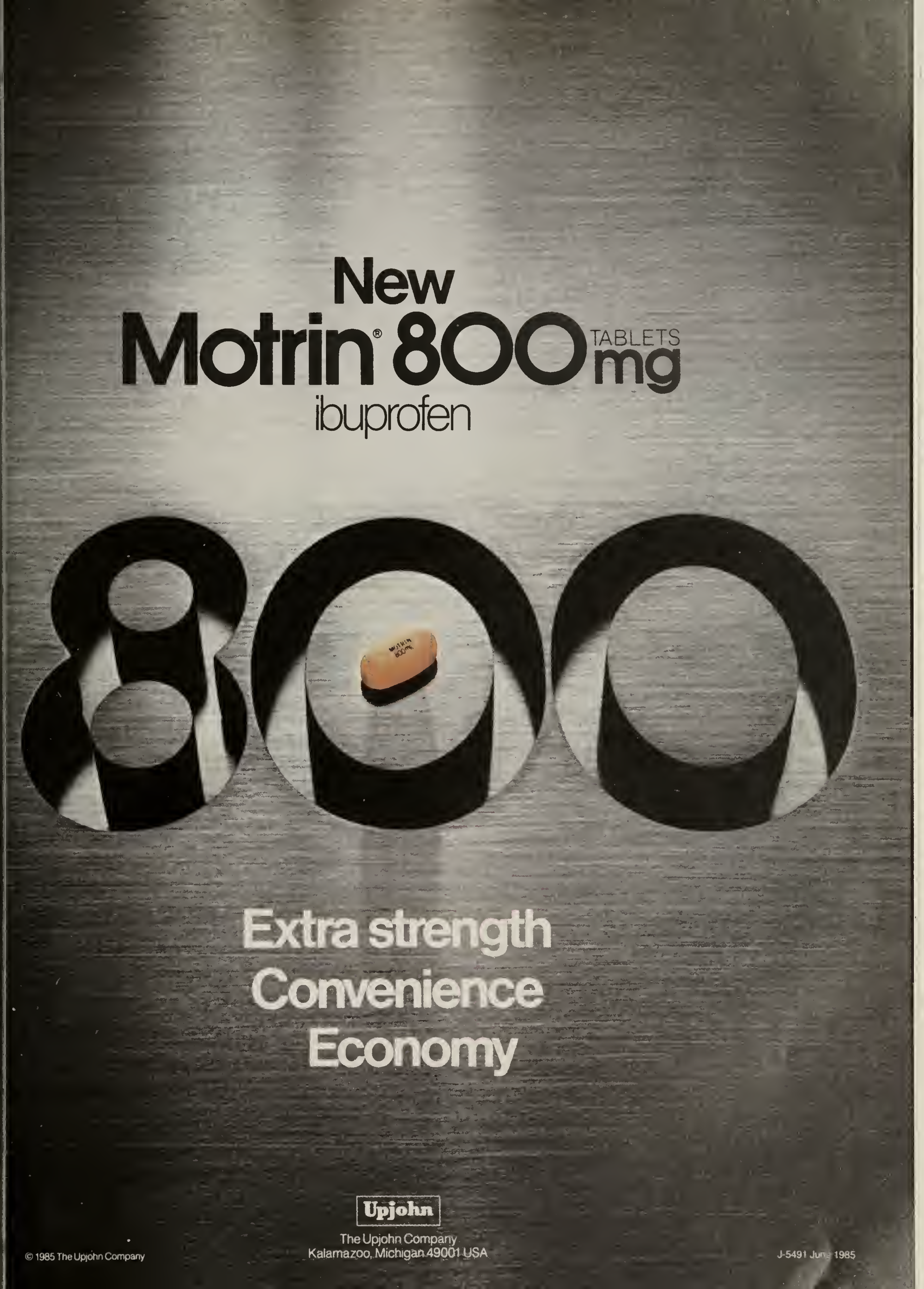

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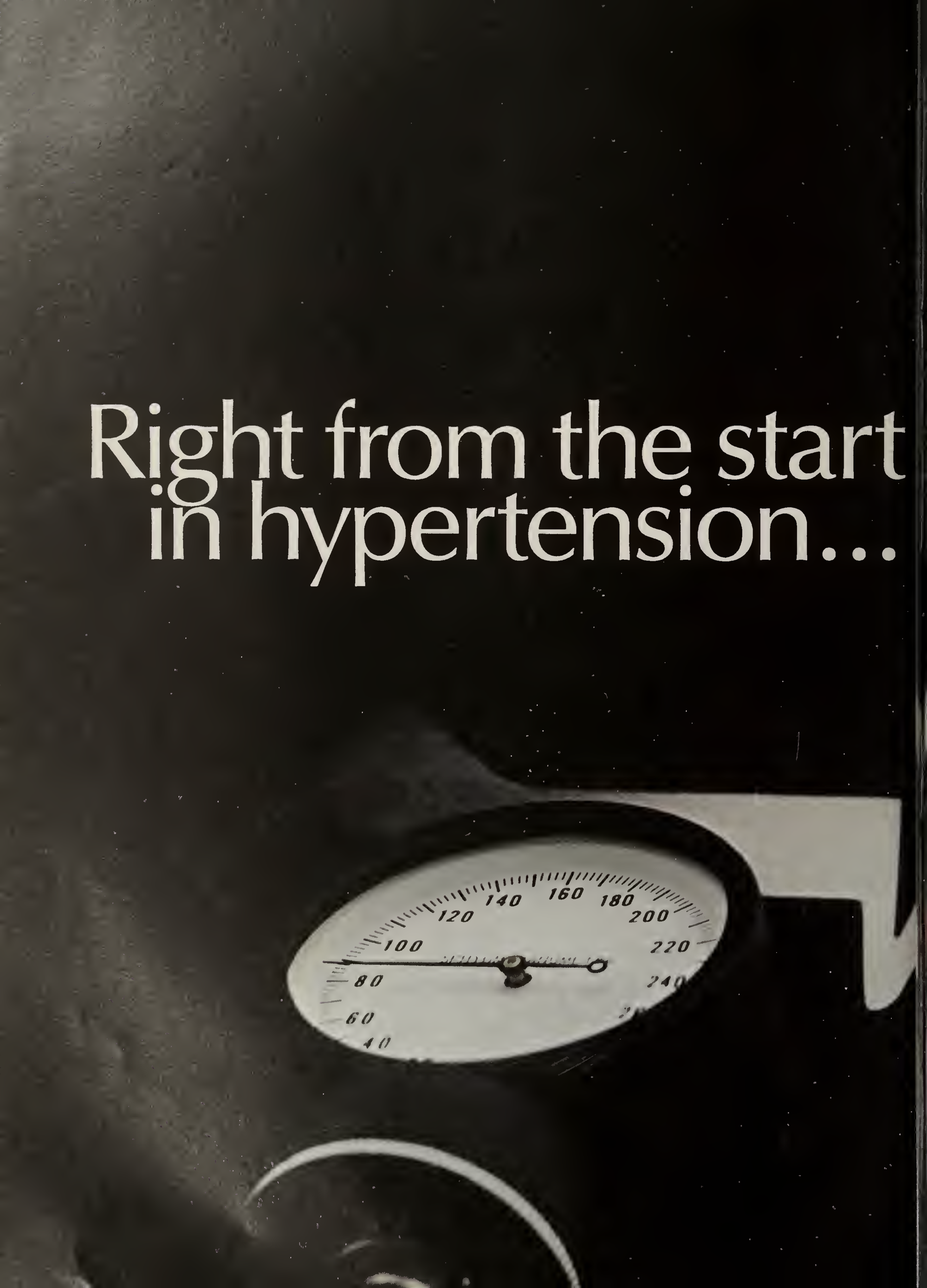
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Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

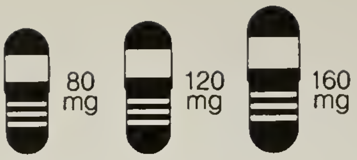
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.



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INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g., dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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Sabina Schwan, clinic coordinator, in the Department of Audiology at Harper, said, "There is no other Assistive Listening Devices and Systems (ALDS) center in Michigan and only one other in the entire midwest."

ALDS demonstrations will be available to all hearing aid candidates for a nominal fee. For more information about the listening device center and Harper Hospital's complete range of audiology services call (313)494-4651.

Medicaid reimburses aspirin for arthritis

Through cooperative efforts of the Arthritis Foundation, Michigan Pharmacists Association, the Michigan Department of Social Services and other study groups, Medicaid began reimbursing for aspirin on July 1, 1985. The aspirin inclusion may actually result in a savings for the Department, given the cost of other less safe non-steroidal anti-inflammatories.

A prescription is required for aspirin reimbursement and there will be no recipient co-payment. Due to the wide price variance between many types of aspirin products, therapeutic drug price limitations for general types of products were set. Listed below are the aspirin types which reflect the varying strengths covered for each product type within the therapeutic drug price limit: Aspirin Tablet, 5 grain or 325 mg.; Aspirin Tablet, 10 grain, 500 mg. or 650 mg.; Aspirin Enteric Coated, Tablet, 5 grain or 325 mg.; Aspirin Enteric Coated, Tablet, 10 grain, 500 mg. or 650 mg.; Aspirin and Antacid Combinations, (Buffered) Tablets, 5 grain or 325 mg.

Products that were not economical were deleted. Pharmacies and drug wholesalers were then surveyed regarding the estimates of average costs to pharmacies for the remaining therapeutic types. The therapeutic price limit was then set to offer a wide range of quality aspirin products.

Prescribers may choose to indicate the drug products generically as listed above. Pharmacy providers can assist prescribers in the choice of products available at the therapeutic drug price limits.

Any questions regarding the aspirin inclusion should be directed to Medicaid Information Division, Medical Services Administration, PO Box 30037, Lansing, MI 48909 or phone toll free 1-800-292-2550 (outside of Michigan call (517) 373-7605). Please refer to Medical Assistance Program Bulletin –5385-85-04 with your inquiries.

ACP recommends regionalization of lithotripters

Each year approximately one of every thousand adults in the United States will experience the pain, infection or obstruction associated with the formation of stones, such as kidney stones, in the urinary tract system. Using lithotripsy, physicians can fragment stones with directed shock waves. All lithotripsy techniques offer an alternative to surgery for the patient with stones. The American College of Physicians evaluated the various types of lithotripsy for safety and efficacy and has issued recommendations for their use through the College's Clinical Efficacy Assessment Project (CEAP). Because the success of each procedure depends largely upon the experience of the personnel performing the technique, the ACP recommends that both the instruments and personnel required for these techniques be regionalized so that this technology can benefit the largest number of patients.

Although lithotripsy instrumentation is expensive, the ACP believes that use of lithotripsy procedures in the health care system can produce savings in medical costs by decreasing the length of hospitalization, reducing the numbers of surgical procedures, and reducing complication associated with surgery such as infections requiring antibiotics or blood loss that requires blood transfusions. Again, regionalization will be necessary to improve the efficiency of lithotripsy procedures. The College also recommends continued research on

Continued on page 612

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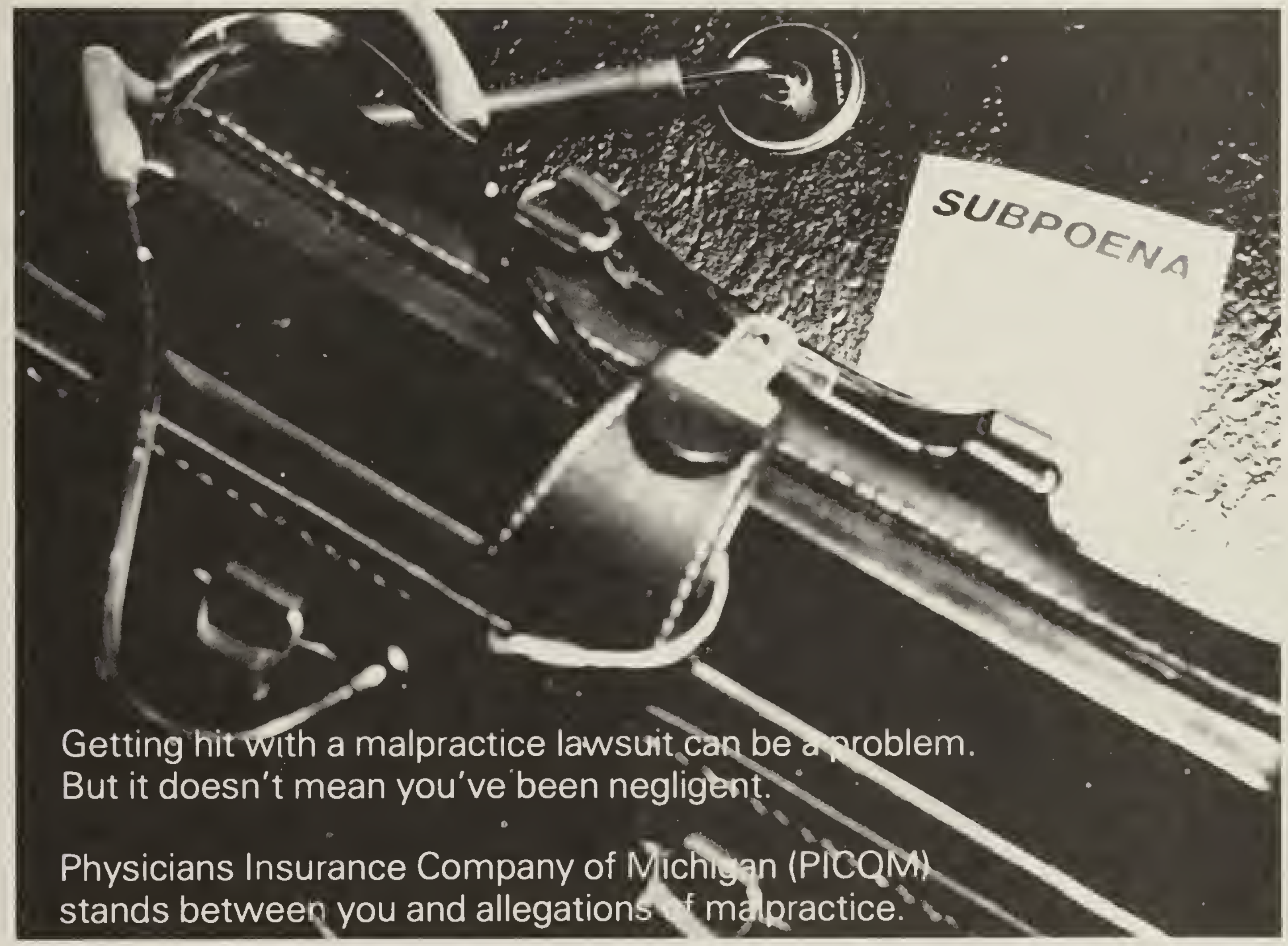

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measures to prevent stone formation and long-term follow-up of patients who have undergone lithotripsy.

Complete copies of this and other CEAP statements may be obtained from the ACP. Write to: American College of Physicians, 4200 Pine Street, Philadelphia, PA 19104.

Study shows Vitamin C delays development of cancer in mice

A three-year study conducted at the Linus Pauling Institute of Science and Medicine and funded largely by the National Cancer Institute has shown that the development of breast cancer in mice is considerably delayed by the addition of large amounts of dietary Vitamin C.

The mice used were bred to show a high incidence of spontaneous mammary tumors. The delay of the tumor onset increased with the amount of Vitamin C administered.

The results of the study, published in the *Proceedings of the National Academy of Sciences*, are consistent with an earlier study at the Institute which showed that added dietary Vitamin C decreases the incidence of skin tumors produced in hairless mice by exposure to ultra-violet radiation. In addition to investigation of the nutritional approach in the prevention and management of cancer, two other major cancer research programs are underway at the Institute to identify and characterize cancer-related genes.

In the laboratory of Molecular Carcinogenesis, directed by Doctor John Leavitt, the focus is on cloning genes present in human tumor cells that have undergone mutation or altered regulation.

A further study, directed by Doctor Raxit Jariwalla in the Laboratory of Viral Carcinogenesis, is focusing on characterizing the transforming genes present in oncogenic human herpes viruses that are capable of converting normal cells in culture into tumor cells.☐

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Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Gertrude C. Black, MD
Action,/Date Taken: Summarily Suspended. Effective 6/26/85.
Reason: Dispensing Controlled Substances for other than legitimate or professionally recognized therapeutic purposes.

Name: Gertrude C. Black, MD
Action,/Date Taken: Surrender of CS License. Effective 8/14/85.
Reason: Dispensed Controlled Substances for other than legitimate or professionally recognized therapeutic purposes.

Name: Henry B. Bright, MD
Action, Date Taken: Revoked and fined. Effective 6/14/85
Reason: Prescribed, sold, or gave controlled drug for other than lawful diagnostic or therapeutic purposes; Departed from minimal standards of care.

Name: Gail G.L. Li, MD
Action,/Date Taken: Revoked. Effective 2/20/85.
Reason: Conviction of a crime reasonably related to and adversely affecting his ability to practice medicine in a safe & competent manner.

Name: Robert J. Murray, MD
Action,/Date Taken: Three year probation - Effective 5/15/85
Reason: Failed to properly monitor patient's condition.

Name: Atalay M. Murguz, MD
Action, Date Taken: Reprimand - May 15, 1985
Reason: Violation of Amphetamine R338.2302. Improper prescribing.

Name: James F. Speers, MD
Action, Date Taken: Reprimand and Limited - shall not prescribe Controlled Substances for a period of five years, except when working at the Niles Emergency Services, PC, Probation two years. Effective 5/15/85.
Reason: Improper personal use of Controlled Substances.

Name: Lawrence S. Weisman, MD
Action,/Date Taken: Reprimanded and fined. Effective 8/21/85.
Reason: Improper prescribing of amphetamines.

Name: Gail Rogers Williams, MD
Action,/Date Taken: Revoked. Effective 6/15/85.
Reason: Departed from, or failure to comform to, minimal standards of acceptable and prevailing practice of medicine and obtained third party reimbursement by fraud or deceit.

Name: Seymour L. Osher, MD
Action, Date Taken: Limited and Reprimanded Effective 6/14/85
Reason: Prescribed Desoxyn contrary to the provisions of the Amphetamine Rule, 1981, AACS R338.2303.

Name: Ernesto P. Sangalang, MD
Action,/Date Taken: Revoked. Effective 2/20/85.
Reason: Conviction of a crime reasonably related to and adversely affecting his ability to practice medicine in a safe and competent manner.

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Seeking qualified Physician, preferably with interest and experience in Emergency Medicine/Urgent Care, to assume directorship of an Urgent Care Center located in a town of 8000 near a large metropolitan area. Candidates must be board certified or eligible, and committed to quality patient care. Desirable characteristics include leadership ability, the ability to work with the community and its medical staff, good management skills, and progressive thinking. Responsibilities also include providing direct patient care in the Urgent Care Center. Salary competitive with excellent benefits. Send resume to: **BOX 1185.**

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page. 2/84

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

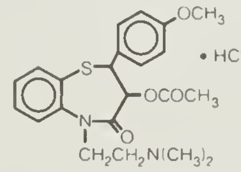
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

November 20 — Practice Management Seminar, Stouffer's of Battle Creek, contact: Donna Farougi, MSMS headquarters (517)337-1351.

December 4 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

January 22, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 19, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

April 11-13, 1986 — AMA's Seventh National Conference on the Impaired Physician, Hilton Hotel and Towers in Chicago, contact: Pat Clark, (312)645-4497.

May 2-3, 1986 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: William Madigan (517)337-1351.

July 17-20, 1986 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

OTHER MEETINGS

November 12-13 — National Conference on Health Policy and Quality of Care for Older Americans, Alexandria, Virginia, contact: 1-800-621-8335.

November 20 — 1985 Physician Recruitment Conference, Providence Hospital, Southfield, contact: Michigan Health Council, 1305 Abbott Road, Suite 106, East Lansing 48823.

March 19-22 — 1986 Great Lakes Athletic Trainers Associations Winter Meeting and Sports Medicine Symposium, Amway Grand Plaza Hotel, Grand Rapids, contact: Lee Kermode, 2317 Gleneagle Drive, Kalamazoo 49001. November 1985 CME Category

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By Herbert Aue

Douglass Houghton, MD: pioneer geologist, physician and leader

Can you identify this early Michigan physician? He is Douglass Houghton, MD. Called by many in Detroit "the little doctor," he was five feet, five inches tall, a little less perhaps. He had light but massive eyebrows and blue eyes "bright and at times merry." Historians describe him as "acute, disciplined and ready, not classical perhaps, not polished but open, frank and truthful."

Q: Can you name the man who can be described as: A brilliant scientist at age 21? A practicing physician in Detroit, who served valiantly during the Detroit cholera epidemic in 1834? Mayor of Detroit at the age of 33 and the first president of the Detroit Board of Education in 1842? First state geologist? Explorer of the Upper Peninsula in 1839-44 who reported the probable extent of copper deposits? Drowning victim in Lake Superior in 1844 while on a geological expedition?

A: Each of these statements describes some aspect of the life of Douglass Houghton, MD.

Very likely most Michigan residents know far more about the years spent by Douglass Houghton working for the federal government and the state of Michigan as a pioneer geologist than they know of his services as a physician.

Houghton comes to Michigan

If it had not been for Professor Eaton at Rensselaer Polytechnic Institute in Troy, North Dakota, in 1830, Douglass Houghton most likely would never have come to Michigan.

Born in Troy September 21, 1809, Houghton was gradu-

Mr. Auer was editor of *Michigan Medicine* for many years and now is a resident of Traverse City. A bibliograph for this article is available from MSMS.

ated from the Rennselaer Polytechnic Institute in 1829 at the age of 20. A brilliant student, he was then appointed as an assistant there in chemistry and natural history. In 1830, friends of science in Detroit asked Professor Eaton, principal at Rensselaer, to recommend someone to give a series of lectures to keep Detroiters abreast of scientific discoveries. Professor Eaton recommended young Doug, then only 21. A committee agreed. Houghton arrived in Detroit in mid-November with a letter of introduction and "only ten cents" according to family members. He presented 26 lectures on botany, geology, chemistry, electricity and magnetism. A ticket for the series was available for $2. He was supported through a subscription fund drive led by Lewis Cass, Zina Pitcher, MD, Michigan delegate to Congress, Lucius Lyon and other prominent men in the community.

The lectures were "largely attended, very interesting and illustrated by brilliant experiments." They were held in the old Detroit Council House, then on the corner of Jefferson and Randolph.

After the lecture series, he returned to New York and was admitted in the spring of 1831 to medical practice by the Medical Society of Chatauqua County, New York. He had studied medicine there under the direction of Squire White, MD, a physician friend of his father.

Houghton practices medicine

He returned to Detroit and was appointed surgeon and botanist that spring for a federal expedition led by his friend Henry R. Schoolcraft to explore the upper reaches of the Mississippi River and Lake Superior. At the end of the expedition he returned to Detroit by boat from the Soo.

Then Houghton began the practice of medicine and dentistry on Jefferson, not far from the Council House where he had lectured. The next spring, he married Harriett Stevens, a childhood friend from New York. They moved into a new home at 19 Wayne Street between Jefferson and Larned and later lived on Miami Avenue.

"Doctor Houghton gained an extensive practice in Detroit," according to C.B. Burr, MD, of Flint, who compiled a two-volume *Medical History of Michigan* published by the Michigan State Medical Society in 1930. "Doctor Houghton took rank as one of our leading physicians," reported George W. Stark, president of the Detroit Historical Society, in the *Blain Hospital Bulletin*, February, 1947.

"In 1834 when cholera visited Detroit with such fearful results no one could have been more devoted or made greater sacrifices to solace the sick and dying than young Houghton," according to *Michigan Pioneer And Historical Collections*. He also was very ill during that epidemic.

While serving on expeditions, he vaccinated a great many native Americans. They suffered the terrible effects of the smallpox epidemic of 1782.

"As in the investigation of science so in the practice of medicine, Doctor Houghton could vary old and prescribed methods. As a physician in a large practice his success was great, working with his skill and knowledge and with tender regard and care of a friend; the sound of his voice would cheer the desponding patient as much for him as medicine," wrote Alvah Bradish in his *Memoir of Douglass Houghton*, published in 1889. Mr Bradish was the husband of Doctor Houghton's sister Lydia.

There are several historical references to a medical partnership of Doctor Houghton, Doctor Pitcher and Randall S. Rice. Doctor Pitcher was the first president of the Wayne County Medical Society, president for 14 years of the Michigan Medical Society and mayor of Detroit three terms. Doctor Rice served seven years as secretary of Michigan Medical Society and long was active in the examination of young physicians for licensure.

During his medical practice, Doctor Houghton never relaxed his studies in science and he gave up his active practice in 1837 when he was appointed the first state geologist.

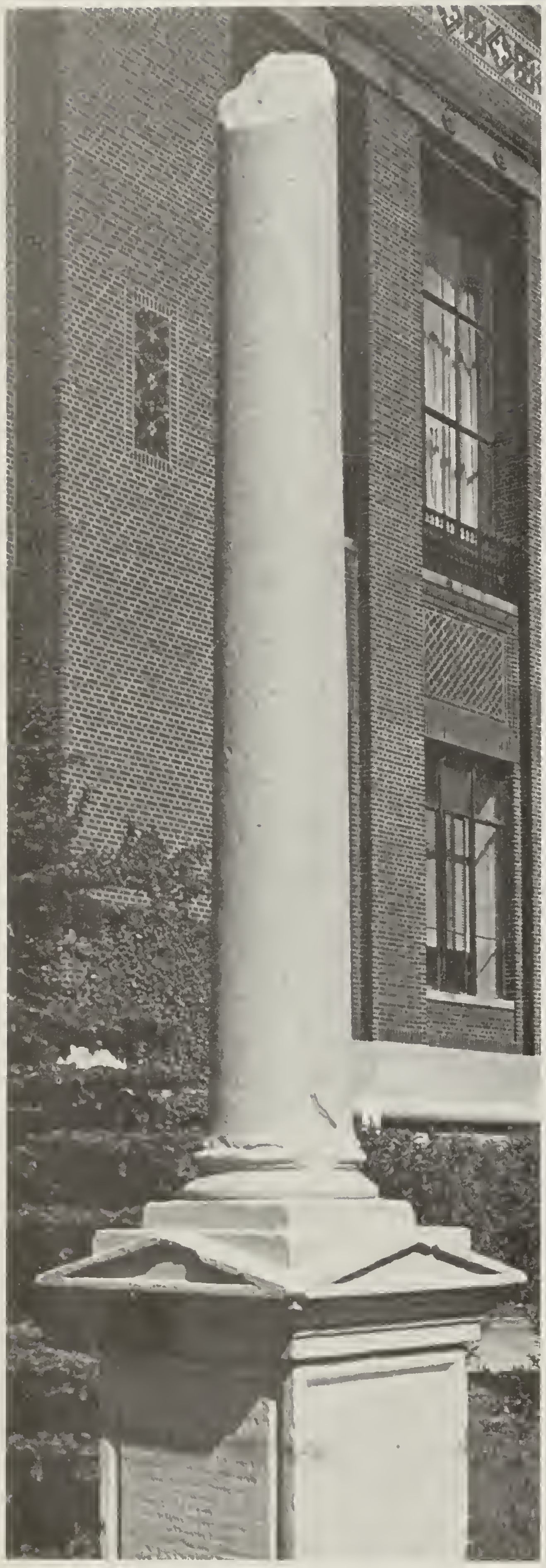
A leading citizen

Doctor Houghton understandably would be involved in community life and Detroit and Michigan government because he "was associated with all that was most cultural in the

Continued on page 621

Organized medicine in Houghton's time

The physicians in Michigan during Houghton's life were members of the Michigan Medical Society, which operated from August 10, 1819 until 1851. The Peninsula Medical Society replaced it on March 10, 1853 and declined during the Civil War. The Michigan State Medical Society was organized in 1856.☐



This monument on the University of Michigan campus bears a tablet on one side of the base honoring Douglass Houghton, MD, who served as professor of chemistry, mining and geology in the early days of the U-M Medical School.

HOUGHTON/Continued

life of Detroit citizens," according to *Michigan Pioneer And Historical Collections*.

He was elected mayor of Detroit in 1842 while in the northern woods. He was reluctant but consented. He served only one term. That same year, Doctor Houghton, Doctor Pitcher and others organized the first Detroit public school system. Doctor Houghton served as president of the first school board that year.

In the spring of 1845, his name was prominently mentioned for governor, just as he was leaving for a summer of surveys in the Upper Peninsula. He wrote a letter explaining that he would not accept the nomination by the Democratic party "unless it be with the hearty concurrence of our party. . . and in such a way to unite the whole party." He was not nominated.

There are delightful written accounts of his visit in the White House as a guest of President Tyler.

Pioneer geologist

As a geologist and botanist, Doctor Houghton was a pioneer in the explorations of Michigan from 1831 until his death in 1845.

During that period he filed seven extensive reports with the legislature and federal government. He commented on salt springs, deposits of copper, gypsum, coal, peat, marl, clay, limestone and iron ore, and he discovered gold in the Upper Peninsula.

Soon after appointment as state geologist, he was appointed by University of Michigan as professor of geology and found time to lecture, collect specimens and counsel on administrative affairs.

Historians claim that the influence of his reports on copper-bearing rocks in the Keweenaw Peninsula not only attracted capital to the Copper Country but hastened the construction of the first canal and locks around the falls of the St. Mary's River.

Houghton drowns

The tragic story of Houghton's death while on a geological survey is told by a friend, Peter McFarland, in *Suander's Cyclopedia Of Medical Biography*. Houghton, McFarland, three other men and Houghton's faithful black and white spaniel Meemee left Eagle Harbor October 14, 1885, in an open sailboat for a camp 10 miles away. The boat left in the dark in a threatening storm, snow and a very high wind. An enormous wave capsized the boat and al went under. The doctor was raised from the water by Peter. "Cling to the keel, doctor," he cried.

"Never mind me," said Houghton, "go ashore if you can — be sure I'll get there without aid."

McFarland and another man reached the shore. "But three including Doctor Houghton sank and did not rise," McFarland wrote. Houghton's body was recovered the next year and there was a large service held in Detroit.

A monument was erected in Elmwood Cemetery, Detroit, to honor him. An interesting monument was dedicated at Eagle River near the scene of his death, as was a cenotaph on the campus of the University of Michigan. The U-M monument monument inscription, in part, honors Doctor Houghton with these words "In science learned, in action prompt, while boldly engaging in public duty." The Douglass Houghton School, no longer in use, was named in 1866 in Detroit in his honor. The school was in the center of Corktown, on Abbott between Brooklyn and Eighth. The best known portrait of Houghton by Alvah Bradish, husband of his sister Lydia, is on display in the Geological Survey Division office in the Stevens T. Mason Building in the Lansing Capitol complex. ☐

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By Katharine S. Brow

Setting up a trust now facilitates transfer upon death

Many years ago, my father established a trust. With the help of an attorney, he wrote a trust agreement which stated that while he lived he was both trustee and beneficiary of the trust. He also retained the right to change or end the trust.

He thus created a revocable living trust. Further, the trust agreement provided that upon his death, I was to be the successor trustee. Finally, as successor trustee, I was charged with distributing the remainder of the trust in equal shares to my brother and myself.

After creating the trust, my father then transferred everything he owned—his house, car and all investments — to himself as trustee. Though no gains or losses were recognized, actual transfer was made and the assets were retitled. In doing this, he created a separate legal entity for owning his assets. He became, in effect, two persons. This meant that he had to maintain two separate sets of books — one for the trust and for himself.

Purpose

Then, because all his investments were in the trust, so was all the investment income. Therefore, periodically he would distribute the income from the trust to his personal account. He was thus acting as both trustee and beneficiary.

As you might guess, this dual system also required that he file two income tax returns — a Form 1040 for himself and a Form 1041 for the trust. Actually, the return for the trust simply showed that all earnings were paid to him as beneficiary — money in and money out. All trust income was ultimately taxed on his personal return just as though the trust didn't exist.

Therefore, the use of the trust resulted in no income tax savings. Nor would it provide any reduction in estate tax, because he retained full control of the trust. If it wasn't to save taxes, what was the purpose of the trust?

The reason my father established and funded his revocable living trust was to avoid the cost, annoyance, lack of freedom, delay, publicity and general frustration so often encountered in making the transition from personal ownership to an estate and then to beneficiaries.

When my father died, all of his assets came under my full control almost immediately. As successor trustee, I needed only to obtain a copy of the death certificate to begin acting as the owner of the trust assets.

To be sure, I was acting for both my brother and myself, but there was no need for probate, "freezing" of accounts or other hassles. The trust continued to exist just as it had before. Eventually, both federal and state estate tax filings were made and taxes due were paid. Then when the remainder was distributed as provided in the agreement, the trust finally ceased to exist.

A revocable living trust is a document used to create a separate legal entity to which you can transfer all or any part of you assets. During your lifetime, though the assets are no longer in your name personally, they remain under your full control. Thi is because you retain the right t change the terms or even to revoke the trust. You also may ad or withdraw assets. This control persists even if you name someone else or a bank as the trustee.

Painless

While living, you (the grantor or settlor) of the trust remain in the same position as before. Thus for income tax purposes the trus is ignored, except for the additional filing required. Then, upon your death, the trustee or successor trustee continues to handle the assets as before with no outside authority involved, no publicity, no need for legal actio and no interruption in the economic life of the family.

You don't have to be wealthy to benefit from a revocable living trust. In fact, the saving of probate costs and other fees may be proportionately important to small estates because they may represent the only costs — assuming exemption from federal and state taxes.

In sum, the revocable living trust is a simple, relatively painless way of transferring estates and as such should be considered as a planning option by most individuals. Your attorney will be helpful in making this evaluation.

Ms. Brown is an account executive with Prescott, Ball and Turben, investment bankers and brokers, East Lansing.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan aw. Sponsors of Category I programs and courses in Michigan are invited to submit nformation for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: November 12-14, 1985 Annual Scientific Meeting, "From Here to Eternity." Location: Hyatt Regency, Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Sherry L. Fent, MSMS headquarters. **Approved for:** 18 hours of Category I Credit.

Date: November 13-14, Advances in Pediatric Hematology/Oncology. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313)876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 15-16, Making Babies — Can We Do It Better? Location: Scott Hall, Wayne State University. **Sponsor:** Wayne State University School of Medicine. **Contact:** WSU Division of Continuing Medical Education, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 11 hours of Category I Credit.

Date: November 18-22, Tutorial on Level II Craniosacral Manipulative Technique. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: November 20, 1985, Current Concepts in Lipid Lowering Therapy. Location: Bronson Methodist Hospital, Kalamazoo. **Contact:** Charles L. Zeller, Jr. MD, Stryker Ctr., 4th Floor, 1521 Gull Rd., Kalamazoo 49001 (616)388-7877. **Approved for** 3.5 hours of Category I Credit.

Date: November 20, A Clinical Day on Alcoholism. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital, CME Committee. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 Category I Credits.

Date: November 21-22, Ear, Nose and Throat Practicum. Location: Towsley Center, Ann Arbor. **Sponsor:** U/M Medical School, Dept. of Postgraduate Medicine and Health Professions Education and Dept. of Otolaryngology-Head & Neck Surgery. **Contact:** Jolene Glaspie, Towsley Center, Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 16.5 hours of Category I Credit.

Date: November 23-25, Tutorial on Fundamental Principles of Manual Medicine as Applied to the Extremities. Location: Kellogg Center, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 24 hours of Category I Credit for MDs and DOs.

Date: December 2-6, Principles of Manual Medicine. Location: Kellogg Center, MSU. **Sponsors:** MSU College of Osteopathic Medicine and College of Human Medicine and North American Academy of Manipuative Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU, East Lansing. (517)353-9714. **Approved for:** 40 hours of Category I Credit for MDs and DOs.

Date: February 12, 1986, Pediatric Neurology. Location: St.John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: February 26, (plus five once-a-week sessions March 5,12,19,26,) Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-502. **Approved for:** 3 hours of Category I Credit.

Date: March 12, 1986, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

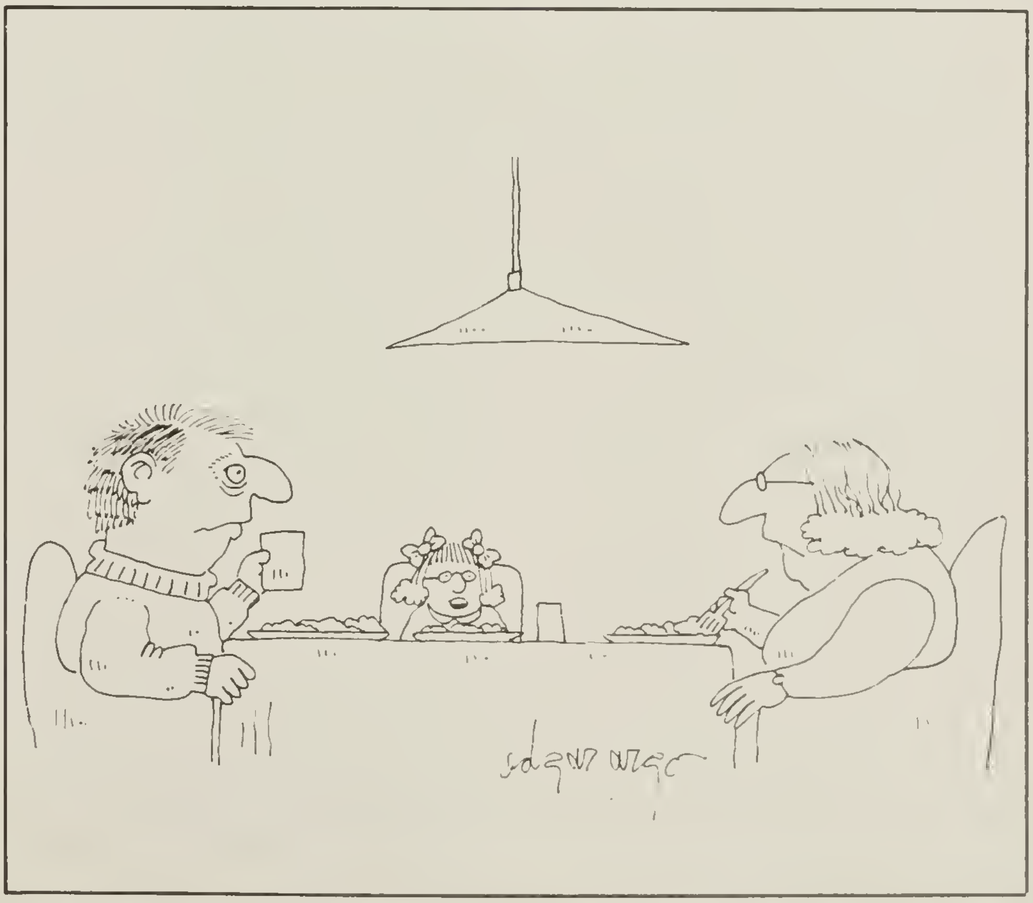
Date: April 7-9, 1986, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, 1986, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 16, 1986, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: January 26-31, 1986, Tenth Annual Midwinter Family Practice Update. Location: Hilton Shanty Creek, Bellaire. **Contact:** Jolene Glaspie, Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313)763-1400. **Approved for** 20 hours of Category I Credit.

Date: April 23, 1986, Cancer Prevention and Early Detection. Location: Genevieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001. **Approved for** 6 hours of Category I Credit.



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DEATHS

Ivor Berry, MD Kalamazoo
Doctor Berry died September 1 at the age of 60. He graduated from the University of Michigan Medical School in 1954. Doctor Berry specialized in OB/GYN and was affiliated with Bronson Methodist and Borgess hospitals.

Gregoire R. Bolduc, MD Flint
Doctor Bolduc died August 19 at the age of 55. He received his degree in OB/GYN from Laval University of Medicine, Quebec and was chief of OB/GYN at St. Joseph Hospital.

Seymour Friedman, MD Traverse City
Doctor Friedman died August 23 at the age of 62. He graduated from McGill Medical School, Montreal, in 1947. Doctor Friedman served as chief of staff at Annapolis and Outer Drive hospitals, and was chief of surgery at St. Mary's Hospital.

Edgar Kahn, MD Ann Arbor
Doctor Kahn died August 19 at the age of 85. He was professor emeritus of surgery at the University of Michigan Medical Center. He received his medical degree from the University of Michigan in 1924 and became head of neurosurgery at the U-M Medical Center in 1949. Doctor Kahn was a former president of the Society of Neurological Surgery and he received its Distinguished Service Award in 1984.

William E. McGarvey, MD Spring Arbor
Doctor McGarvey died August 8 at the age of 93. He came to Jackson in 1924 after his graduation from the University of Buffalo Medical School. Doctor McGarvey was a past president of the Jackson County Medical Society.

Frank O. Novy, MD Saginaw
Doctor Novy died August 13, 1985 at the age of 91. He was a 1919 graduate of the University of Michigan Medical School. Doctor Novy was chief of surgery and anesthesiology at Saginaw General Hospital. He practiced medicine for 46 years in Saginaw.

Harold M. Podolsky, MD Southfield
Doctor Podolsky died August 16 at the age of 67. He received his MD degree from from Wayne State University in 1942. Doctor Podolsky retired from active practice in 1982.

Alvin Price, MD Pleasant Ridge
Doctor Price died September 19, 1985 at the age of 84. He graduated from the University of Michigan Medical School in 1927. Doctor Price practiced internal medicine from the 1930's until 1970 and was on staff at Harper Hospital for 50 years.

Raymond E. Sculley, MD El Paso, Texas
Doctor Sculley died August 9 at the age of 85. He received his medical degree from Wayne State University in 1927 and had practiced medicine in Burton Heights for 50 years.

Martin C. Sharp, MD Grayling
Doctor Sharp died August 8 at the age of 70. He received his degree in medicine from the University of Louisville Medical School and practiced medicine in Saginaw from 1947 until his retirement in 1978.

Daniel H. Sheeran, MD Flint
Doctor Sheeran died July 14 at the age of 79. He received his medical degree from Wayne State University School of Medicine and had practiced medicine in Flint since 1937. He specialized in OB/BYN, surgery, and anesthesiology.

Herbert M. Shellenberger, MD Marshall
Doctor Shellenberger died July 16 at the age of 76. He received his medical degree from the University of Michigan Medical School. Doctor Shellenberger came to Marshall after World War II and practiced medicine there until his retirement in 1963.

Edward P. Sliwin, MD Dearborn
Doctor Sliwin died August 8 at the age of 75. He received his medical degree from Wayne State University School of Medicine in 1937. Doctor Sliwin was on staff at Providence and Oakwood hospitals.

Robert Swedenburg, MD Muskegon
Doctor Swedenburg died August 16 at the age of 64. He earned his medical degree from Temple University in Pennsylvania in 1948 and opened his Muskegon practice in 1956. Doctor Swedenburg was past president of the Muskegon County Medical Society.

S. John Yu, MD Bay City
Doctor Yu died August 15 at the age of 41. He received his medical degree from the Medical School of Yonsei University, Seoul, Korea in 1969. Dr. Yu had practiced neurology in Bay City since 1974.□

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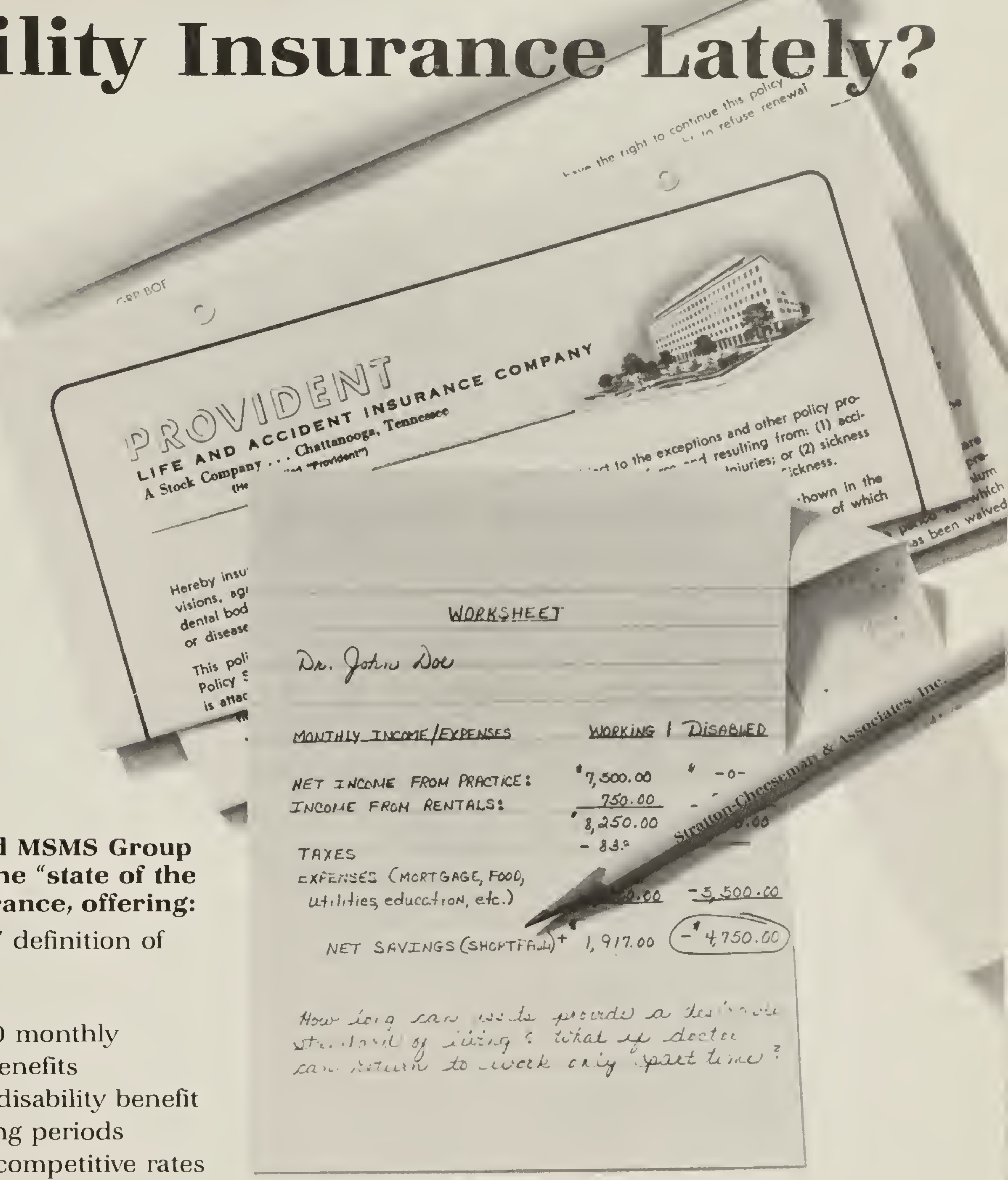
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Dr. John Doe

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HE GENERAL MEDICINE DIVISION OF ENRY FORD HOSPITAL is seeking a seasonl, innovative, General Internist to assume the adership position for executive medical proams. Interested persons should contact Wilmer Rutt, MD, Associate Chairman, Department Medicine, Henry Ford Hospital, 2799 W. Grand oulevard, Detroit 48202. Telephone: (313)876- 74.

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By Richard J. McMurray, MD

Rally was an expression of patient advocacy

These comments are taken from Doctor McMurray's address on the Capitol steps during the October 22 "Onward to Lansing" rally for professional liability reform. They are printed here for the benefit of our members who remained at home that day to care for patients, and to *remind all physicians to contact their legislators.* There still is much to be done.

Welcome to Lansing! As your president, I am proud to have the pleasure of greeting you today. Never before has such a body of physicians and friends of medicine come to the steps of this Capitol building to rally *peacefully* and enthusiastically in support of a governor and legislators who are working to solve a societal problem. We are here to help our legislators in every way we can to bring about changes which will benefit and facilitate the delivery of health care for the people of the state of Michigan.

I recognize your being here today as another expression of physicians being advocates for our patients.

Under the leadership of Lou Zako, MSMS has been working for the past year to develop a multi-faceted approach to medical liability. The legislative package is of prime concern today, but in addition, we have long term approaches in place:

1. Commissioned research;
2. Less cumbersome arbitration forms;
3. Expanded and enhanced risk management — a renewed diligence in recording the facts;
4. Promotion of a fully effective Board of Medicine, with improved funding and immunity;
5. Investigation and development of alternate solutions, such as programs similar to workers' comp and no-fault insurance;
6. A methodology to care for the damaged patient, whether by malpractice or maloccurence.

Medical liability is the tip of the iceberg in the overall picture of the liability issue. It now includes all units of government, retailers, manufacturers, schools and even daycare centers. The chaos in the liability system is about to bring a collapse of the entire judicial system.

We have heard that the problem is the tremendous profits being made by the insurance companies. Of ten companies writing medical liability policies in 1975 in Michigan, only three still are offering service in our state — 70 nationwide. One does not find insurance companies paying out twice what they take in and still making huge profits. According to the Michigan Insurance Bureau, MPMLC paid out $2.11 for every $1 it took in during 1981. Does that sound profitable?

An important aspect of the legislative package puts a cap on pain and suffering or noneconomic losses. This limit is $250,000. This cap is in addition to awards granted for actual economic losses such as medical expenses, loss of income or projected loss of income.

These facts are not commonly understood. We *must* stress that this is *in addition to all other compensations.* We *must* stress this point when we talk with our legislators.

We are here to present information that will help lawmakers understand what is happening to the people of our state and in our profession — and what can happen if changes are not made. This includes ever-increasing costs for medical care and other services, the curtailment or withdrawal of services and the *loss of Michigan physicians.*

We are here to dramatize a serious situation so lawmakers can understand how severe it really is.☐

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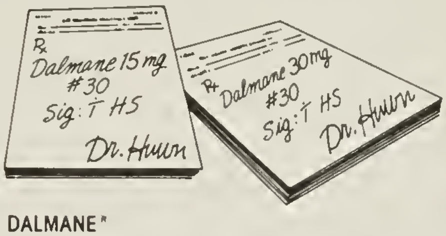
References: 1. Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971 **2.** Kales A, *et al. Clin Pharmacol Ther 18*.356-363, Sep 1975 **3.** Kales A, *et al: Clin Pharmacol Ther 19*.576-583, May 1976. **4.** Kales A, *et al. Clin Pharmacol Ther 32*.781-788, Dec 1982 **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979 **6.** Dement WC, *et al. Behav Med*, pp 25-31, Oct 1978. **7.** Kales A, Kales JD. *J Clin Psychopharmacol 3*.140-150, Apr 1983 **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977.



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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended Repeated therapy should only be undertaken with appropriate patient evaluation

Contraindications: Known hypersensitivity to flurazepam HCl, pregnancy Benzodiazepines may cause fetal damage when administered during pregnancy Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam Instruct patients to discontinue drug prior to becoming pregnant Consider the possibility of pregnancy prior to instituting therapy

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia Consider potential additive effects with other hypnotics or CNS depressants Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported headache, heartburn, upset stomach, nausea, vomiting diarrhea constipation, GI pain, nervousness, talkativeness apprehension irritability weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of leukopenia granulocytopenia sweating flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia euphoria depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e g* excitement, stimulation and hyperactivity

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MICHIGAN MEDICINE

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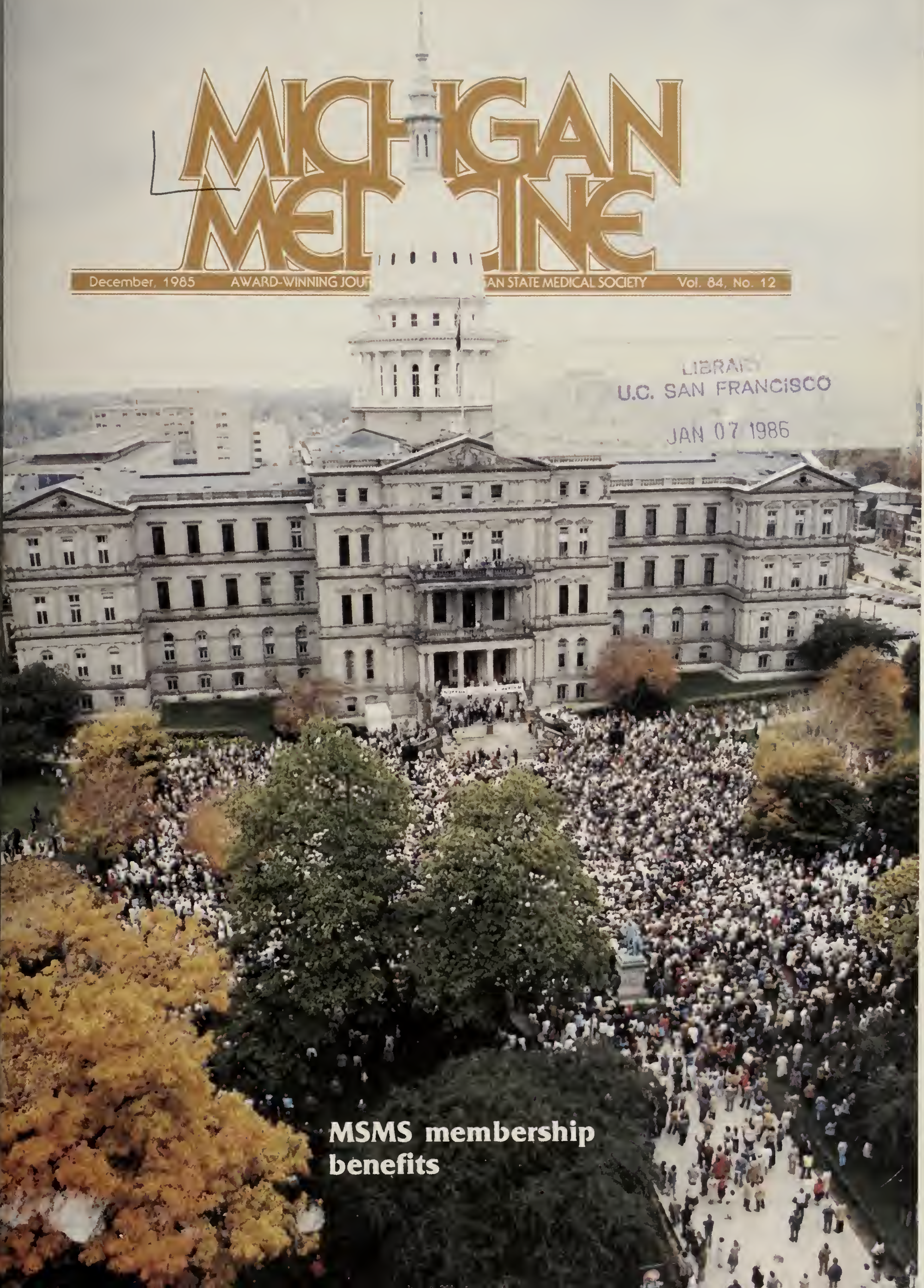

MSMS membership benefits

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Managing Director: William E. Madigan

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Michigan State Medical Society Membership Insurance Benefits

Are you aware of the insurance available to you as an MSMS member?

On the following two pages is a summary of the member benefit insurance coverages which are available to you through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Membership, Operations and Meeting Planning, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).

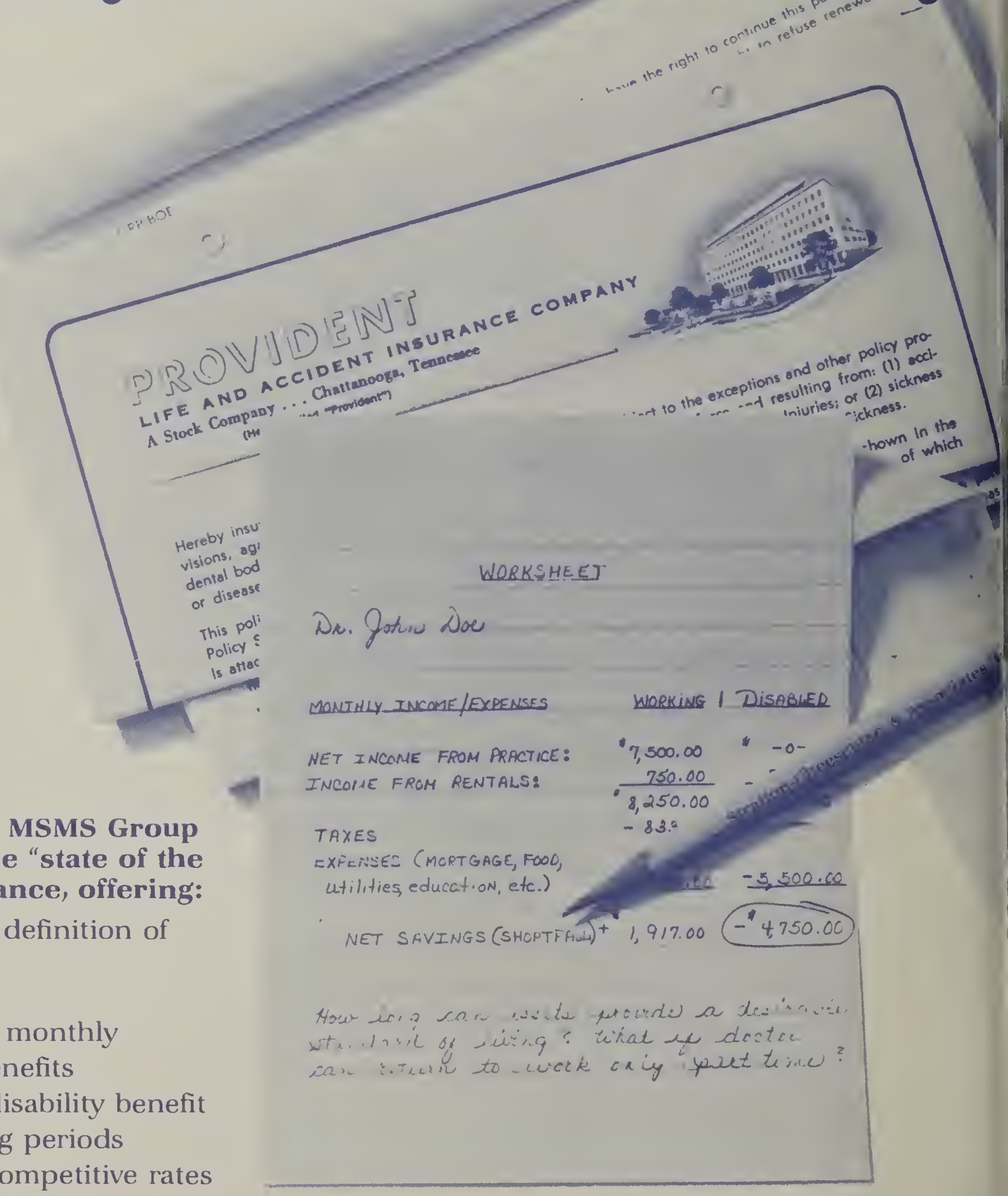
Please remove this insert for handy reference in your files.

Insurance benefits available for Mich

Type	Coverage Available	Special Features
1. **Disability Income Protection Accident & Sickness**	Optional amounts up to $2,500 monthly benefit. Benefits paid from the 30th day, or 90th day of disability; and, benefit duration is lifetime for accident and to age 65 for sickness. Coverage automatically includes waiver of premium and up to one-fourth the monthly indemnity for non-disabling injuries. The plan is underwritten by Provident Life & Accident insurance Company, Chattanooga, Tennessee.	"Your specialty" definition of total disability. Res tial benefits payable to age 65. New member teed $500 monthly benefit, regardless of medic Guaranteed conversion if member leaves th continue full time practice in another state. C pro-rated because of benefits received from ot ance.
2. **Business Overhead Disability Coverage**	Optional amounts up to $5,000 monthly benefit. Reimbursement for office expenses; i.e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expe are deductible from gross income befo (IRS, 55-264, I.R.B. 1955-19, p. 8).
3. **Term Life Insurance**	Available in amounts of $25,000, $50,000, $75,000 or $100,000. Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.	New MSMS members guaranteed $ regardless of medical history. Parti members are eligible to share any di that become payable. Guaranteed con to ordinary life if membership is disco Conversions also available to Perman at age 65 reduction and age 70 terminatio
4. **Special Accidental Death & Dismemberment Benefits**	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of $25,000, $50,000, $75,000, or $100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member's principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Around-the-clock protection and wo coverage. Sports and recreation as well fessional duties are fully covered. Rene age 70.
5. **Disability Income Protection For Employees of Members**	Available in various amounts up to $500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-year accident/two-years sickness. Waiver of premium included. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense wh by the employer.
6. **MEDGARD Professional Liability Insurance**	Limits of $100,000/$300,000; $200,000/$600,000; $1,000,000/$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company.	A 75% premium discount to first-year pra ers; 25% discount for second-year practi 50% for most part-time or semi-retired phys No charge for P.C./partnership coverag mium financing available.
7. **MEDGARD Property & Liability Insurance**	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost covera surance designed specifically for phys Competitively priced. Advantage of one pany — total coverage.
8. **Hospital/Medical/Major Medical Dimension III**	Excellent benefits to cover hospital, medical and major medical services. A separate benefit program is available for employees.	Three option coverages available to phy and their families, from comprehensiv benefits to Dimension III with deductibl copayments and a lower premium.

tate Medical Society members

nistrators	Eligibility/How to Apply
n-Cheeseman & Associates, Inc. Abbott Road, P.O. Box 1563 ansing, Michigan 48823	All MSMS members, under age 66, residing in Michigan, practicing full-time, may apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
on-Cheeseman & Associates, Inc. Abbott Road, P.O. Box 1563 ansing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
on-Cheeseman & Associates, Inc. Abbott Road, P.O. Box 1563 Lansing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.
ton-Cheeseman & Associates, Inc. Abbott Road, P.O. Box 1563 Lansing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the state of Michigan are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
ton-Cheeseman & Associates, Inc. Abbott Road, P.O. Box 1563 Lansing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
tton-Cheeseman Management Company, Abbott Road, P.O. Box 1563 Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
tton-Cheeseman Management Company, Abbott Road, P.O. Box 1563 Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for specific information. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
Cross and Blue Shield of Michigan Lafayette East . J113 oit, Michigan 48226	Available to all MSMS members and their employees. Enrollment kit is available from MSMS Department of Member Services, 120 W. Saginaw St., East Lansing, 48823 (517) 337-1351.



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WORKSHEET

Dr. John Doe

MONTHLY INCOME/EXPENSES	WORKING	DISABLED
NET INCOME FROM PRACTICE:	$7,500.00	$ -0-
INCOME FROM RENTALS:	750.00	[illegible]
	$8,250.00	[illegible]
TAXES	- 833	[illegible]
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.)	[illegible]	-5,500.00
NET SAVINGS (SHORTFALL)	+ 1,917.00	-$4,750.00

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December 1985, Vol. 84, No. 12

MICHIGAN MEDICINE

MICHIGAN MEDICINE
MSMS membership benefits

bout the cover: More than 2,000 physicians, their milies, patients and other iends of medicine converged n our state Capitol October 2 to support professional ability reform legislation. hat rally was an awesome emonstration of what MSMS embers have known all long — there is strength in umbers. **Photo by Pattrick ockey.**

Special report

634 "What does Michigan State Medical Society do for me?" As dues time rolls around, you may ask yourself that question. In answer, this month's Special Report outlines MSMS membership benefits and leadership. It begins with an explanation of sponsored insurance programs on the insert opposite this page. Tangible and intangible benefits are touted by MSMS' Membership Recruitment and Retention Chairperson, as well as by a student member. Lists of component societies and committees follow, and a pie chart shows you where your dues go; Cathie O. Blight, MD, and Judy Marr

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In next month's issue of *Michigan Medicine:* The 1986 Conference on Maternal and Perinatal Health, "Twenty-five years of Growth and Change," will be highlighted.

Order your souvenir set of rally photos!

MSMS has selected six color photos representing the excitement of the entire "Onward to Lansing" rally day. Use the form at right to order.

Send me ________ sets of six 8" x 10" color photos of the October 22 MSMS rally in Lansing. I have enclosed a check for (@ $40 per set) for a total of $________ made payable to Michigan State Medical Society.

Name________________________________

Address________________________________

City________________ State________ Zip________

By Leland E. Holly, II, MD

Why quality is in trouble

Holly

I believe third-party payors conscientiously mandate saving quality as well as dollars. They simply think they are paying too much for quality.

They know what dollars are. Dollars are completely measurable. Everybody knows where they come from, what they are used for, how they are used and where they go.

The problem is the policy-makers do not know what quality is. Worse, no one else does either.

Yes, everybody has this "feeling" for quality but no one can comprehensively measure it. In the absence of a measurable and consistent definition, no one knows what quality is, how to improve it, how to maintain it, when it's gone or how it was lost.

How much does quality cost? When does saving dollars degrade quality? What determines quality? What is the acceptable trade-off between dollars and quality? When everything is known about the dollar and next to nothing is known about quality, what chance does quality have?

The problem is defining "quality." Unless everyone agrees to its shape and substance quality can never stand up to the dollar.

In my opinion, the greatest challenge facing medicine and society today is to assemble a practical, working and measurable definition of quality in medical care. We should get on with it.

Doctor Holly is MSMS treasurer.

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Managing Editor
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Michigan Medicine, the official journal of the Michigan State Medical Society, i dedicated to provide useful information for Michigan physicians about actions o the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editori board of *Michigan Medicine* and advise the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or featur published in the pages of the journal. Th views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserve the right to accept or reject advertising copy. Products and services advertised i *Michigan Medicine* are neither endorse nor warrantied by MSMS.

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lembers react to Rally

is letter was received by
rl A. Gagliardi, MD, Chair-
an, MSMS Board of Direc-
rs:

On behalf of the medical
aff of Gratiot Community
ospital, we would like to con-
atulate you as well as the
her members of your team,
ho organized the most im-
essive rally seen within the
st years at our State Capitol.
ongratulations are also ex-
nded to the Society's staff
ersonnel.
The Medical Staff of Gratiot
ommunity Hospital is ready to
ontinue to support our society
its just campaign supporting
ur legislators in liability
eform.

Victor V. Rozas, MD
Chairman
Political Action and
Community Education
Committee
Gratiot Community Hospital

Mr. Kevin Kelly, Manager, MSMS Department of Government Relations, received this letter in late October.

I had the distinct privilege of participating in the "Onward to Lansing" rally. When I contemplated participation, I had misgivings about the value of the exercise, spending time away from practice, etc. Fortunately, I was not dissuaded from going because I would have missed being part of the most outstanding organizational effort and demonstration of the democratic process that I've ever seen or heard of.

I cannot tell you how proud I am to be associated with you and your fellow staff of MSMS, and how much I appreciate your efforts on behalf of our patients and our profession. Whatever the legislative outcome, this was a worthwhile exercise. Please extend my congratulations to everyone at MSMS for this outstanding job.

Sheldon F. Markel, MD
Ann Arbor

By Cathy O. Blight, M

Some of the best MSMS benefits are intangible

"What does Michigan State Medical Society do for me?"

That question often is asked of those of us concerned with membership in organized medicine. From my perspective, the advantages can be divided into tangible and intangible benefits.

The tangible benefits are rather easy to define. At the state level, some of the benefits offered to MSMS members include this journal, *Michigan Medicine*, accreditation and courses for CME credits and provision of group insurance for its members. With the support and efforts of MSMS, Michigan Physicians Mutual Liability Company was formed during the last professional liability crisis to provide affordable insurance for MSMS members. Through the years it has continued to do so, today insuring some 5,000 physicians in the state. MSMS Physician Service Group offers a variety of practice management aids including office computerization, bill collecting and patient credit card usage for physician services.

With the addition of AMA membership, a physician receives *JAMA*, a specialty journal (such as *Archives of Neurology*), and the *AM News*. Other publications, video clinic courses, practice management workshops and video cassettes are a few of the other benefits available to the AMA member.

Recently, the AMA Membership Development Department put together a savings comparison chart, comparing the cost to a non-member and member of a defined list of benefits available through the AMA. If the member took *JAMA*, a specialty journal, the *AM News*, bought the book *Current Procedural Terminology*, took a video clinic course, a practice management workshop, bought a practice management video cassette, utilized the Standard Market Area Profile, the placement service, MINET, the AMA Library Computer Document Search, a Physician Recognition Award and a Hertz rental car, that member would save $523.75 over a non-member. If, in addition, that physician invested $10,000 in the AMA Equity Fund instead of in a Keogh plan, he/she could save up to an additional $765.00 for a total savings of up to $1,289.00.

A unified voice

As important as tangible benefits are, the intangible ones are just as vital. An organization of peers and colleagues to speak as a unified voice for physicians and as an advocate for patients is important in this time of encroachment on the practice of medicine by government and other forces. Through a democratic system such as organized medicine, the concerns of all physicians can be addressed.

The recent rally at the Lansing Civic Center and State Capitol, coordinated by MSMS. gave the physicians of Michigan the chance to voice their concerns about the professional liability problem to thei legislators. The MSMS rally was extremely successful, due to the well- organized, well-financed, professional organization which was able to draw on extensive resources. No individual could have organized and staged such a successful event. No individual could have mobilized the vast number of physicians who cut across geographical and specialty lines.

Two groups supporting this effort and other efforts of organized medicine are students and residents. They typically do not avail themselves of many of the benefits, but they feel very strongly the advantages of organized medicine.

The question

With all of these tangible and intangible reasons for joining, the question arises, "Why isn't every physician a member of organized medicine?" The answers are as many and varied as the people who give

---

Doctor Blight is chairperson, MSMS Committee on Membership Recruitment and Retention.

them, but it is imperative that we counter with sound facts and logic. In the coming year we need to urge non-members of our organization to *become* members. Over the past year the Membership Committee, in conjunction with the AMA has encouraged peer-to-peer recruitment, and many successful efforts have taken place.

Still, of the 17,947 practicing physicians, residents and students, only 10,687 are MSMS members and 10,144 are AMA members. I would hope we can continue our efforts to encourage many of these non-members to join their voices with ours for the good of all. I encourage those physicians who do not maintain unified membership in their county society, MSMS, and the AMA to seriously consider the importance of unification.

Many of our students and residents are AMA-direct members depriving MSMS of their energies and good ideas. We would like to invite them to become active in their state and county societies. We must convince all physicians that in this time of upheaval, a strong professional organization is vital to our continued well-being and to that of our patients. Events such as the Lansing rally can happen only with the continued support of our members.

By Judy Marr, Editor

A student's view

"Why I joined MSMS"

Laurie McKeown, University of Michigan Medical School senior, has known about organized medicine since a tender age.

"*JAMA* has been around the house a lot of years," explains the daughter and niece of long-time physicians. Therefore, she says, she formed an early interest in becoming a member of the MSMS and AMA Medical Student Sections.

"But now that I'm involved, I see a lot more reasons for belonging," she says.

"The AMA and its affiliates represent physicians as a whole," she says. "The organization looks out for physicians' and patients' interests."

Benefits she's found since joining include:

1) Active members serve as role models for new members, "for the way we will practice medicine in the future.

"We students have seen doctors giving up time and pay to contribute to their communities. They are the kind of quality people students look up to."

2) Education on issues plays a large part in MSMS and AMA medical student section activities.

"This is a time of rapid change in medicine and it's somewhat confusing," she observes. "It's hard to keep abreast. And it's even more important to join when you don't know what lies ahead."

3) Membership is a good way for students to develop skills, to learn abut the legislative process, how organized medicine operates, and how to participate.

"It's wonderful of MSMS and AMA to give students a place on committees," she says. "It helps us develop leadership for the future and adds to the academic education we are getting."

4) "The wonderful people I have met." She admits she did not foresee this benefit. She tells enthusiastically of AMA President-elect John J. Coury's appearances at U-M medical student functions and the role modeling of female physicians such as MSMS Director Marguerite Shearer, MD, Dexter.

"We need to make membership more attractive to women," she says. "If we don't reach out to them, encourage them to join and to lead, the numbers will drop."

Laurie herself is very active. She is a U-M Medical School delegate to the AMA Medical Student Section (each school is entitled to an alternate and a delegate).

She's a member of the national governing council of the AMA Medical Student Section and is the student member on the advisory panel for the AMA Women in Medicine Project.

Laurie, who will apply this year for a neurology residency, says she couldn't have accomplished all she has without support on the county and state levels of medicine.

"All the help, the role models, the expertise — these are the things that really encourage and nurture the Student Section," she says. "State medical leaders need to be commended. They have done a lot of work for us and I don't think they always get the credit.

"I just want them to know the Student Section appreciates them."☐

Component societies have close ties to Board and staff

Every component medical society is represented on the MSMS Board of Directors by one or more elected physicians, depending on the size of that group's membership. In addition, an MSMS staff member is assigned as liaison and resource person to each component society. These contact persons are indicated below.

ALLEGAN COUNTY
Director: B. David Wilson, MD
Staff: Kirk McMurray

ALPENA-ALCONA-PRESQUE ISLE COUNTIES
Director: Harvey M. Andre, MD
Staff: Jerome Trahan

BARRY COUNTY
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Kornelius VanGoor, MD
Staff: Katie Brewbaker

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Staff: Katie Brewbaker

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Staff: Sherry N. Wellman, Jerome Trahan

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Director: Jack L. Barry, MD
Staff: Thomas E. White

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Director: Justin L. Sleight, MD
Staff: Wayne E. Burmeister

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Staff: Sherry N. Wellman, Jerome Trahan

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Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

INGHAM COUNTY
Director: Justin L. Sleight, MD
Staff: Judith E. Marr

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Kornelius Van Goor, MD
Staff: Thomas E. White

IOSCO COUNTY
Director: Charles L. Oppy, MD
Staff: Kevin A. Kelly

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Staff: Vada L. Davis

JACKSON COUNTY
Director: Justin L. Sleight, MD
Staff: Ellen Vinocur Potash

KALAMAZOO COUNTY
Director: B. David Wilson, MD
Staff: Linda Munson

KENT COUNTY
Directors: Harvey M. Andre, MD;
Kornelius Van Goor, MD
Staff: Linda Munson

LAPEER COUNTY
Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

LENAWEE COUNTY
Director: Marguerite Shearer, MD
Staff: Daniel Farhat

LIVINGSTON COUNTY
Director: Marguerite Shearer, MD
Staff: Daniel Farhat

LUCE COUNTY
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman, Jerome Trahan

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Directors: Frederick W. Bryant, MD;
Billy Ben Baumann, MD;
Joel W. Clay, MD
Staff: John A. Richards

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Director: John W. Hall, MD
Staff: Thomas E. White

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Staff: Sherry N. Wellman, Jerome Trahan

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Staff: Kirk McMurray

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Staff: Sherry N. Wellman, Jerome Trahan

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Staff: Deborah Zannoth

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Staff: Daniel Farhat

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NORTH CENTRAL
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Staff: Richard M. Campau

NORTHERN MICHIGAN
Director: John W. Hall, MD
Staff: Deborah Zannoth

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Billy Ben Bauman, MD;
Joel W. Clay, MD
Staff: Kevin A. Kelly

OCEANA COUNTY
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Staff: Wayne E. Burmeister

ONTONAGON COUNTY
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman, Jerome Trahan

OTTAWA COUNTY
Directors: Harvey M. Andre, MD;
Kornelius Van Goor, MD
Staff: Kirk McMurray

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Director: Kenneth B. Herrington, MD
Staff: Ellen Vinocur Potash

ST. JOSEPH COUNTY
Director: William D. Walters, MD
Staff: John A. Richards

SAGINAW COUNTY
Director: Jack L. Barry, MD
Staff: Kevin A. Kelly

SANILAC COUNTY
Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

SCHOOLCRAFT COUNTY
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman, Jerome Trahan

SHIAWASSEE COUNTY
Director: Richard L. Rapport, MD
Staff: Sheri W. Greenhoe

TUSCOLA COUNTY
Director: Jack L. Barry, MD
Staff: Richard M. Campau

VAN BUREN COUNTY
Director: B. David Wilson, MD
Staff: Sheri W. Greenhoe

WASHTENAW COUNTY
Director: Marguerite Shearer, MD
Staff: John A. Richards

WAYNE COUNTY
Directors: Henry M. Domzalski, MD;
Carl A. Gagliardi, MD;
James J. Humes, MD;
Kenneth J. Ray, MD;
Arthur A. Ulmer, MD;
Frank B. Walker, MD
Staff: Bruce W. Ambrose, William Madigan

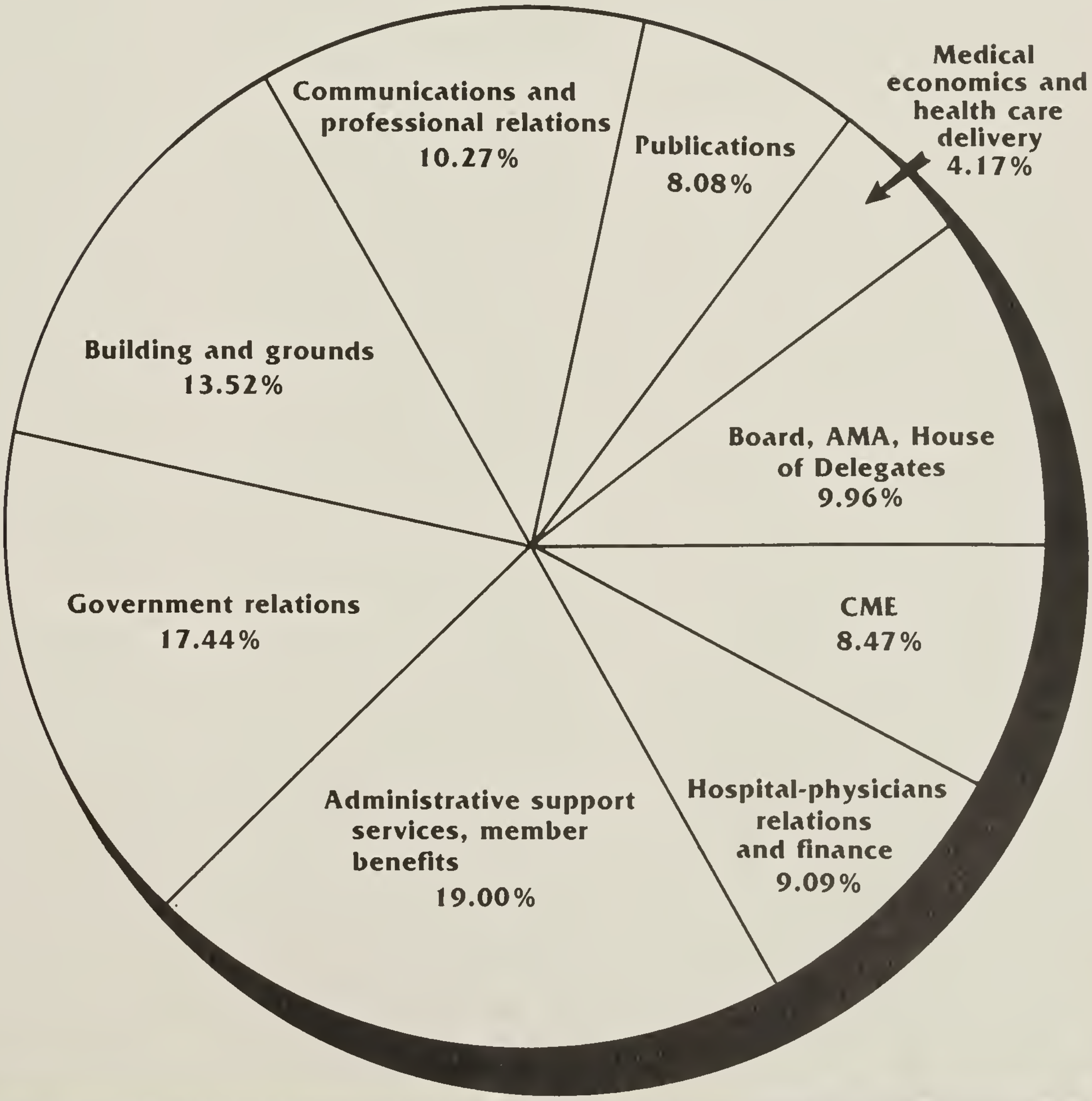
WEXFORD-MISSAUKEE COUNTIES
Director: John W. Hall, MD
Staff: Richard M. Campau

Membership fees for your state medical society, which remain at $290 for 1986, are parceled out prior to the MSMS fiscal year which begins December 1. Making the decisions are members of the Finance Committee of the MSMS 1985 Board of Directors, chaired by Jack Berry, MD, Saginaw.

The Finance Committee acts on the recommendations of the MSMS Budget Subcommittee to the Finance Committee and spends many hours during the fall months analyzing every projected expense and revenue item. They obtain final approval for the budget from the MSMS Board of Directors.

The pie chart below illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is published to give MSMS members a clearer idea of how MSMS revenues are spent. ☐

Where your dues go



MSMS committees shape the society's future

COMMITTEE ON AGING

This Committee examines the health status of senior citizens, issues regarding financing of the Medicare program and long term health care for the elderly. Activities include advocating preventative medicine programs and providing physicians with an overview of the medical, social and psychological needs of the aged patient. The Committee works with many community organizations and the State Office of Services to the Aging.

William T. Bateman, MD, Chairman, Kalamazoo
Harvey M. Andre, MD, Grand Rapids
Mrs. Donna Chase, Grand Rapids
Diane A. Culik, MD, Detroit
David H. Deitrick, MD, Muskegon
Phillip M. Green, MD, Kalamazoo
Robert A. Holmes, MD, Lansing
Brooker L. Masters, MD, Fremont
James G. O'Brien, MD, East Lansing
Harry E. Schneiter, MD, Grand Rapids
Frederick C. Swartz, MD, Lansing
Robert J. Toteff, MD, Detroit
Richard H. Wakulat, MD, Petoskey
Sumer D. Verma, MD, East Lansing
Thomas J. Northey, Consultant, Lansing
Janet Olszewski, Consultant, Lansing
James Tarrant, Consultant, East Lansing
Deborah Zannoth, Staff Assistant

PLANNING COMMITTEE FOR MSMS ANNUAL SCIENTIFIC MEETING

The Planning Committee under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

Rudi Ansbacher, MD, Ann Arbor, Co-Chairman
Samuel M. McMahon, MD, Lansing, Co-Chairman
Frederick W. Bryant, MD, Royal Oak
Kenneth L. Krabbenhoft, MD, Pleasant Ridge
Nicholas J. Lekas, MD, Dearborn
Joan C. Stryker, MD, Detroit
Sherry L. Fent, Staff Assistant

ADVISORY COMMITTEE ON OFFICE AUTOMATION

The Committee advises staff in its plan for automation of MSMS office operations.

Frank B. Walker, MD, Chairman, Grosse Pte. Farms
Jack L. Barry, MD, Saginaw
Leland E. Holly, II, MD, Muskegon
Robert E. Paxton, MD, Fremont
Vada L. Davis, Staff Assistant

LIAISON COMMITTEE WITH AUXILIARY

The Liaison Committee advises the MSMS Auxiliary, on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

R. Jack Chase, MD, Chairman, Grand Rapids
Dale R. Drew, MD, Pontiac
Peter A. Duhamel, MD, Rochester
Viola Heins, Staff Assistant

COMMITTEE ON AWARDS

The Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Justin L. Sleight, MD, Chairman, Lansing
Robert M. Leitch, MD, Battle Creek
Frank B. Walker, MD, Grosse Pte. Farms
Katie Brewbaker, Staff Assistant

COMMITTEE ON BIOETHICS

The Committee considers questions about scientific, medical, moral, ethical and political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and therefore MSMS.

Frederick W. Bryant, MD, Chairman, Royal Oak
Howard A. Brody, MD, East Lansing
Mrs. Betty Drew, Bloomfield Hills
Gary S. Gustafson, MD, Berkley
James T. Harrison, MD, Grand Ledge
John V. Hartline, MD, Kalamazoo
George F. Newman, MD, Dearborn
Evan J. Reinders, MD, Muskegon
Marguerite Shearer, MD, Dexter
Kornelius Van Goor, MD, Grand Rapids
Sherry N. Wellman, Staff Assistant

COMMITTEE ON CHILD ABUSE AND NEGLECT

The MSMS Committee on Child Abuse and Neglect was established as a focal point for medical concerns related to child abuse. Its purpose is to increase physician awareness about the problems of child abuse and to initiate or participate in programs to promote the detection and reporting of child abuse.

Barbara Meyer Lucas, MD, Chairman, Detroit
Alexa Canady, MD, Detroit
Mrs. Dottie Csonka, Essexville
Ruben S. Kurnetz, MD, Birmingham
Clyde L. Owings, MD, Ann Arbor
Douglas A. Sargent, MD, Grosse Pte. Farms
Jack M. Stack, MD, Alma
Natalia M. Tanner, MD, Detroit
Mark H. Tucker, MD, Battle Creek
Dennis A. Wagner, MD, Sanford
Ray E. Helfer, MD, East Lansing, Consultant
Daniel R. Farhat, Staff Assistant

COMMITTEE ON CONCERNS OF WOMEN PHYSICIANS

This Committee explores ways to encourage the participation and leadership involvement of women physicians in organized medicine.

Vivian M. Lewis, MD, Chairperson, Flint
Susan E. Adelman, MD, Detroit
Anna M. H. Broecker, MD, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Miriam S. Daly, MD, Albion
S. Margaret Davies, MD, Chelsea
Margaret E. Jones, MD, East Lansing
Robert E. Paxton, MD, Fremont
Rhoda M. Powsner, MD, Ypsilanti
Marguerite Shearer, MD, Dexter
Natalia M. Tanner, MD, Detroit
Robert J. Toteff, MD, Detroit
Kathleen L. Yaremchuk, MD, Dearborn
Linda Munson, Staff Assistant

COMMITTEE ON CONTINUING MEDICAL EDUCATION ACCREDITATION

This Committee maintains standards to assure that quality CME activities are available to Michigan physicians through review, evaluation, and accreditation of continuing medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Vice-Chairman, Alpena
Gail I. Bank, PhD, Detroit
ames C. Breneman, MD, Galesburg
Allen D. Damschroder, MD, Petoskey
Roland G. Hiss, MD, Ann Arbor
Mark D. Kolins, MD, Grosse Pointe
oseph F. Marshall, MD, Saginaw
ohn W. Moynihan, MD, Dearborn
Michael W. Radke, PhD, Lansing
Robert K. Richards, PhD, Grand Rapids
Victor V. Rozas, MD, Alma
oseph A. Sentkeresty, MD, Grand Rapids
Robert L. Tupper, MD, Grand Rapids
W. Donald Weston, MD, East Lansing
Charles L. Zeller, MD, Kalamazoo
Katie Brewbaker, Staff Assistant

COMMITTEE ON CONTINUING MEDICAL EDUCATION PROGRAMMING

The Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to co-sponsor programs which meet the CME criteria for Category I.

Samuel M. McMahon, MD, Chairman, Lansing
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Robert E. Birk, MD, Detroit
Frederick W. Bryant, MD, Royal Oak
Richard E. Dean, MD, East Lansing
Clyde R. Flory, Jr., MD, Lansing
Michael J. Giacalone, Jr., MD, Flint
Terry Kinzel, MD, Hancock
David C. Leach, MD, Detroit
Daniel E. Leb, MD, Bloomfield Hills
Richard A. Lemmer, MD, Kalamazoo
David R. Rovner, MD, East Lansing
George L. Royer, Jr., MD, Kalamazoo
Helen J. Scoblic, MD, Bad Axe
Joan C. Stryker, MD, Detroit
James Tarrant, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

COMMITTEE ON CONSTITUTION AND BYLAWS

This standing committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

Earl G. Moehn, MD, Chairman, Mt. Clemens
Thomas F. Higby, MD, Fowlerville
Murray G. Kling, MD, Detroit
James E. McGillicuddy, MD, Lansing
John H. McLaughlin, MD, Birmingham
A. Stewart Kerr, Consultant, Detroit
William E. Madigan, ex officio, East Lansing
Vada L. Davis, Staff Assistant

LIAISON COMMITTEE WITH CORPORATE MEDICAL DIRECTORS

The Liaison Committee meets with medical directors of corporations to discuss common interests and recommend appropriate courses of action.

Richard H. Gascoigne, MD, Chairman, Adrian
Duane L. Block, MD, Dearborn
William K. Emery, MD, St. Joseph
Adam E. Gamon, MD, Brandt
David Jacknow, MD, Detroit
David C. Laderach, MD, Detroit
William N. Richardson, MD, Pontiac
Kirk McMurray, Staff Assistant

ADVISORY COMMITTEE ON HEALTH CARE POLICY

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

Kenneth J. Ray, MD, Chairman, Trenton
Billy B. Baumann, MD, Pontiac
Robert B. Carbeck, MD, Ann Arbor
James D. Fryfogle, MD, Southfield
George R. Gerber, MD, Rochester
John V. Hartline, MD, Kalamazoo
Terrell K. Hebert, MD, Grand Haven
D. Bonta Hiscoe, MD, East Lansing
Robert A. Mengebier, MD, Petoskey
Marguerite Shearer, MD, Dexter
Donald C. Smith, MD, Farmington Hills
Mary Anne Ford, Staff Assistant

STEERING COMMITTEE ON PROGRAM TO ASSIST IMPAIRED PHYSICIANS

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

Carl A. Gagliardi, MD, Chairman, Dearborn
Michael Boyle, DO, Troy
John B. Bryan, MD, Royal Oak
Robert H. Hydrick, MD, Grand Rapids
Bobbe J. Kelley, DO, West Bloomfield
William J. Kube, MD, Kalamazoo
Douglas W. MacDonald, MD, Oxford
Mrs. Cathie Martin, Traverse City
Joyce W. Mason, MD, Ann Arbor
Stephen C. Mason, III, MD, Ann Arbor
Tom R. Miles, DO, Traverse City
Richard A. Morin, MD, Ann Arbor
Robert Niccolini, MD, Detroit
John T. O'Connor, DO, Lansing
Justin L. Sleight, MD, Lansing
Russell F. Smith, MD, Whitmore Lake
Gerald A. VanderVoord, MD, East Lansing
Katie Brewbaker, Staff Assistant

JUDICIAL COMMISSION

The Committee has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the

Continued on next page

MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

John H. McLaughlin, MD, Chairman, Birmingham
N. Warn Courtney, MD, Kalamazoo
Edwin H. Gullekson, MD, Flint
Murray G. Kling, MD, Detroit
Robert P. Lilly, MD, Livonia
Adam C. McClay, MD, Traverse City
John H. McLaughlin, MD, Birmingham
George W. Morley, MD, Ann Arbor
Joseph L. Ponka, MD, Detroit
John C. Rienstra, MD, Grand Rapids
Donald N. Sweeny, Jr., MD, St. Clair Shores
A. Stewart Kerr, Consultant, Detroit
Katie Brewbaker, Staff Assistant

COMMITTEE ON STATE LEGISLATION AND REGULATIONS

This Committee monitors and influences Michigan legislation through the legislative process, and monitors and responds to Michigan government rules and regulations as they are promulgated.

Frederick V. Minkow, MD, Chairman, Bloomfield Hills
John R. Addy, MD, Lansing
Robert D. Allaben, MD, Detroit
Michael T. Bergeon, MD, Saginaw
Cathy O. Blight, MD, Flint
Anna M. H. Broecker, MD, Grand Rapids
Bruce R. Deschere, MD, Sterling Heights
John A. Feemster, MD, Detroit
Mrs. Lillian Fields, Parma
Richard P. Heuschele, MD, Saginaw
Richard P. Horsch, MD, Livonia
Robert E. James, Jr., MD, Flint
Dorothy Kahkonen, MD, Detroit
Mrs. Linda Kelly, Muskegon
D'Anne M. Kleinsmith, MD, Detroit
Michael K. Kobernick, MD, Lathrup Village
James E. MacVicar, MD, Kalamazoo
Wilfred E. Maldonado, MD, Lansing
James M. McGillicuddy, MD, Lansing
Charles L. Oppy, MD, Roscommon
Winifred A. Oyen, MD, Midland
John P. Papp, MD, Grand Rapids
John C. Parker, MD, Jackson
Fred E. Patterson, MD, Jackson
Dhanwada S. Rao, MD, Detroit
Mitchell A. Rinek, MD, Lansing
William C. Sharp, MD, Southfield
Marvin L. Starman, MD, Southfield
Willard S. Stawski, MD, Grand Rapids
Thomas E. Stone, MD, Muskegon
Phillip B. Storm, MD, Petoskey
Frank D. VanDeventer, MD, Harper Woods
Charles C. Vincent, MD, Detroit
Frank B. Walker, MD, Grosse Pte. Farms
B. David Wilson, MD, Kalamazoo
Bernard J. Woodley, MD, Trenton
Roger F. Mecum, Consultant, Detroit
Milton Zaagman, Consultant, Lansing
Kevin A. Kelly, Staff Assistant

BOARD OF MANAGERS

The Board of Managers oversees the management of the Capital Reserve Fund, the Creative Reserve Fund and the management of MSMS buildings and grounds.

Leland E. Holly, II, MD, Chairman, Muskegon
Jack L. Barry, MD, Saginaw
Justin L. Sleight, MD, Lansing
Timothy M. Talbott, MD, Grand Rapids
Arthur A. Ulmer, MD, Grosse Pte. Shores
Fred W. Whitehouse, MD, Detroit
Richard M. Campau, Staff Assistant.

COMMITTEE ON MATERNAL AND PERINATAL HEALTH

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

Robert W. Dustin, MD, Chairman, Dearborn
Lloyd A. Kammeraad, MD, Vice-Chairman, Grand Rapids
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
Robert J. Austin, MD, Kalamazoo
C. Arch Brown, MD, Flint
Ralph A. Cram, MD, Albion
Preston V. Dilts, Jr., MD, Ann Arbor
Gerhard C. Endler, MD, Grosse Pte. Woods
Donald S. Frost, MD, Traverse City
James W. Gell, MD, Bloomfield Hills
John W. Hallitt, MD, Flint
John V. Hartline, MD, Kalamazoo
Douglas G. Kinne, MD, Petoskey
Mary J. Kokosky, MD, Dearborn
James G. Kornmesser, MD, Novi
Mrs. Pat Krapohl, Jackson
Don R. Krohn, MD, Southfield
Chang Y. Lee, MD, Detroit
Francis A. Locke, MD, Adrian
Robert P. Lorenz, MD, Royal Oak
Federico G. Mariona, MD, Detroit
Joseph P. Metz, MD, Flint
William H. Michaels, MD, Southfield
Joseph S. Moore, MD, Grand Rapids
Wallace G. Pearson, MD, Marquette
Ronald L. Poland, MD, Detroit
Dorothy A. Porter, MD, Lathrup Village
Roger W. Postmus, MD, Ypsilanti
James W. Sharpe, MD, Port Huron
Joseph L. Sheets, MD, Lansing
Richard E. Smith, MD, Detroit
Robert J. Sokol, MD, Bloomfield Hills
Lee B. Stevenson, MD, Southfield
Carolyn M. Texera, MD, DeWitt
Arthur A. Ulmer, MD, Grosse Pte. Shores
Kenneth A. VanderKolk, MD, Grand Rapids
Daniel J. Wilhelm, MD, Port Huron
George H. Baker, MD, Consultant, Lansing
Mason Barr, Jr., MD, Consultant, Ann Arbor
Mary M. Conklin, RN, Consultant, Lansing
Eugene V. Perrin, MD, Consultant, Detroit
George W. Russian, DO, Consultant, Okemos
Charles H. Sander, MD, Consultant, East Lansing
Mary A. Scoblic, RN, Consultant, Lansing
Kenneth Stringer, DO, Consultant, East Lansing
Richard Yerian, DO, Consultant, Lansing
Katie Brewbaker, Staff Assistant

PLANNING COMMITTEE FOR MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH

The Planning Committee, with input from the MSMS Committee on Maternal and Perinatal Health, plans and implements Category I CME programs for the Annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several other participating organizations.

Joseph P. Metz, MD, Co-Chairman, Flint
Robert W. Dustin, MD, Co-Chairman, Dearborn
John R. Addy, MD, Lansing
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
C. Arch Brown, MD, Flint
Mary M. Conklin, RN, Lansing
Miriam S. Daly, MD, Albion
Steven M. Donn, MD, Ann Arbor
Gregory J. Feldmeier, MD, Kalamazoo
Molly Gates, RN, Ann Arbor
John V. Hartline, MD, Kalamazoo
Joy Hershberger, RN, Grand Blanc
Okjin Kim, RN, Lansing
Mary J. Kokosky, MD, Dearborn
Mrs. Pat Krapohl, Jackson
Robert P. Lorenz, MD, Royal Oak
Chang Y. Lee, MD, Detroit
Federico G. Mariona, MD, Detroit
John G. O'Rourke, MD, Jackson
Evelyn Piehl, RN, Ann Arbor
Dorothy A. Porter, MD, Lathrup Village
Mary A. Scoblic, RN, Lansing
Mindy Smith, MD, Chelsea
Hermann A. Ziel, Jr., MD, ex officio, Perry
Lloyd A. Kammeraad, MD, ex officio, Grand Rapids
Sherry L. Fent, Staff Assistant

MEDICAID LIAISON COMMITTEE

The Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Continued on page 642

Thank you
for the friendship
and good will
you have shown us
throughout
the past year.

◆

May your
Holidays be happy
and your
New Year be
prosperous.

Michigan Physicians
Mutual Liability Company

Cecil R. Jonas, MD, Co-Chairman, Detroit
Allen F. Turcke, MD, Co-Chairman, Flint
Thomas M. Flake, MD, West Bloomfield
James D. Johnston, MD, Traverse City
Robert L. Leeser, MD, Charlotte
Thomas C. Payne, MD, Lansing
Robert J. Toteff, MD, Detroit
Daniel J. Wilhelm, MD, Port Huron
Mary Anne Ford, Staff Assistant

LIAISON COMMITTEE WITH MEDICAL ASSISTANTS

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request, regarding medical assistant activities and problems. It also suggests projects the medical assistants may wish to undertake.

Joseph J. Tiziani, MD, Chairman, Ann Arbor
Arthur L. Brown, II, MD, Kalamazoo
Richard M. Czop, MD, Lansing
Cecilia Hissong, MD, Dearborn Heights
Anton Strocel, MD, Flint
Caroline Rich, Staff Assistant

TASK FORCE ON MEDICAL CARE COSTS

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awareness, and develops cost effectiveness information for the practicing physician. The Task Force publishes articles on cost containment in *Michigan Medicine*.

Richard P. Horsch, MD, Chairman, Farmington Hills
Everette Gustafson, MD, Pontiac
Mrs. Cathie Martin, Traverse City
James E. McGillicuddy, MD, Lansing
B. David Wilson, MD, Kalamazoo
John A. Richards, Staff Assistant

ADVISORY COMMITTEE TO THE DEPARTMENT OF MEDICAL ECONOMICS AND REIMBURSEMENT

The Advisory Committee assists the Department in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Jay K. Harness, MD, Chairman, Chelsea
E. Joseph Alberding, MD, Portage
Joseph J. Berke, MD, Detroit
Gilbert B. Bluhm, MD, West Bloomfield
Frederick B. Brown, MD, Muskegon
John B. Bryan, MD, Royal Oak
Robert B. Carbeck, MD, Ann Arbor
Frank E. Check, Jr., MD, Detroit
James D. Fryfogle, MD, Southfield
Denise G. K. Gray, MD, Detroit
Mrs. Barbara Grennan, Muskegon
Harvey W. Halberstadt, MD, Troy
Robert H. Hamburg, MD, Detroit
Hector J. Inchaustegui, MD, Royal Oak
Margaret E. Jones, MD, East Lansing
Stanley H. Levy, MD, Detroit
Max L. Lichter, MD, Farmington Hills
Richard L. Rapport, MD, Flint
Kenneth B. Schooff, MD, Mt. Clemens
Floyd S. Tukel, MD, Dearborn
Allen F. Turcke, MD, Flint
Frederick W. VanDuyne, MD, Flint
John A. Richards, Staff Assistant

COMMITTEE ON MEDICAL STAFF RELATIONS

The Committee is monitoring establishment of the Hospital Medical Staff Section of the MSMS House of Delegates. It is also considering communication mechanisms for interacting with hospital medical staffs to strengthen and enhance communications between MSMS and its medical staff leader members.

Gary D. Maynard, MD, Chairman, Kalamazoo
Robert D. Allaben, MD, Detroit
Robert W. Black, MD, Detroit
Henry M. Domzalski, MD, Detroit
James J. Humes, MD, Detroit
Devendra K. Sharma, MD, Tawas City
Thomas E. White, Staff Assistant

COMMITTEE ON MEDICAL LICENSURE AND DISCIPLINE

This Committee is to develop a new liaison with the Michigan Department of Licensing and Regulation and seek and support measures that will promote a fully effective Board of Medicine.

Rhoda M. Powsner, MD, Chairman, Ypsilanti
Gilbert B. Bluhm, MD, West Bloomfield
Gerald G. Brueckner, MD, Mt. Clemens
Frederick B. Brown, MD, Muskegon
Henry A. Cartwright, MD, Detroit
Ricardo Chalela, MD, Washington
Carl A. Gagliardi, MD, Dearborn
Robert D. Gibson, MD, Newberry
Denise G. K. Gray, MD, Detroit
Edwin H. Gullekson, MD, Flint
William J. Kube, MD, Kalamazoo
Donald H. Kuiper, MD, Lansing
Laurie McKeown, U-M, Ann Arbor
James A. O'Neill, MD, Clarkston
B. L. Pederson, MD, Bay City
Arthur Rose, MD, Southfield
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Kevin A. Kelly, Staff Assistant

TASK FORCE TO REVIEW MEMBER INSURANCE BENEFIT PROGRAMS

This Task Force reviews existing and proposed insurance benefit programs for MSMS members and makes recommendations to the Board of Directors.

B. David Wilson, MD, Chairman, Kalamazoo
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Kenneth J. Ray, MD, Trenton
William B. Cheeseman, Consultant, East Lansing
Wayne E. Burmeister, Staff Assistant

COMMITTEE ON MEMBERSHIP RECRUITMENT AND RETENTION

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors and conducts personal recruiting efforts when needed.

Cathy O. Blight, MD, Chairperson, Flint
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Wayne E. Burmeister, Staff Assistant

LIAISON COMMITTEE WITH MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

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Kevin A. Kelly, Staff Assistant

MICHIGAN STATE MEDICAL SOCIETY/MICHIGAN HOSPITAL ASSOCIATION LIAISON COMMITTEE

This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

Thomas R. Berglund, MD, Portage
Carl A. Gagliardi, MD, Dearborn
Richard J. McMurray, MD, Flint
Louis R. Zako, MD, Dearborn Heights
Bruce W. Ambrose, East Lansing
William E. Madigan, East Lansing

COMMITTEE ON MSMS POLICY MANUAL

This Committee reviews actions of the House of Delegates and incorporates any policy decisions into the Policy Manual of MSMS.

Robert D. Burton, MD, Chairman, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Leland E. Holly, II, MD, Muskegon
Richard L. Rapport, MD, Flint
Kenneth J. Ray, MD, Trenton
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ADVISORY COMMITTEE ON COMMUNICATIONS AND PROFESSIONAL RELATIONS

This Committee develops and oversees all public relations and public service activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

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Linda L. Martin, Consultant, Lansing
Sherry N. Wellman, Staff Assistant

TASK FORCE ON PROFESSIONAL LIABILITY

The Task Force reviews the professional liability climate in Michigan and the nation, is familiar with proposed reforms, and recommends appropriate legislative or other improvements.

Louis R. Zako, MD, Chairman, Dearborn Heights
Cathy O. Blight, MD, Flint
Mrs. Lois Duhamel, Rochester
Richard H. Gascoigne, MD, Adrian
D. Bonta Hiscoe, MD, East Lansing
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Rhoda M. Powsner, MD, Ypsilanti
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John L. Shek, MD, Saginaw
Charles C. Vincent, MD, Detroit
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Beverly Payne, MD, Consultant, Ann Arbor
Thomas R. Berglund, MD, Advisor, Portage
Carl A. Gagliardi, MD, Advisor, Dearborn
Richard J. McMurray, MD, Advisor, Flint
Gerald H. Mandell, MD, Advisor, Detroit
Richard Weber, Advisor, Detroit
Richard M. Campau, Staff Assistant

COMMITTEE ON PUBLICATIONS

This Committee serves as an advisory board to the editors in determining policy, setting new directions, suggesting subject material, overseeing finances, and reviewing all display advertising for MSMS publications.

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Frederick W. Bryant, MD, Royal Oak
John W. Hall, MD, Petoskey
Leland E. Holly, II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights
Judy Marr, Staff Assistant

COMMITTEE ON RISK MANAGEMENT PROGRAM

This Committee monitors new developments in risk management and aids in the development of risk management programs for MSMS members.

Louis R. Zako, MD, Chairman, Dearborn Heights
Leland E. Holly, II, MD, Muskegon
Robert M. Leitch, MD, Battle Creek
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Richard M. Campau, Staff Assistant

Continued on next page

MSMS/MHA LIAISON/Continued

COMMITTEE OF SPECIALTY SOCIETY PRESIDENTS

This Committee provides for rapid communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

Richard J. McMurray, MD, Chairman, Flint
Michigan Allergy Society: Ilie Magdea, MD, Dearborn
Michigan Society of Anesthesiologists: Gary D. Maynard, MD, Kalamazoo
Michigan Chapter, American College of Chest Physicians: William Conway, MD, Detroit
Michigan Section on Clinical Pharmacology and Therapeutics: George L. Royer, Jr., MD, Kalamazoo
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Michigan Dermatological Society: Howard Dubin, MD, Ann Arbor
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Michigan Society of Gastrointestinal Endoscopy: Ramon R. Joseph, MD, Westland
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Michigan Society of Therapeutic Radiologists: Donald P. Stratton, MD, Muskegon
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Michigan Thoracic Society: John W. Dircks, MD, Kalamazoo
Michigan Branch, American Urological Association: Donald Blain, MD, Mt. Clemens
Sherry N. Wellman, Staff Assistant

COMMITTEE ON SPORTS MEDICINE

This Committee sponsors conferences aimed at physicians and others with an interest in sports medicine. It also provides sports medicine information and medical evaluation of sports rules when requested by the Michigan High School Athletic Association, Inc.

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Roy T. Bergman, MD, Escanaba
Steven K. Campbell, MD, Birmingham
Jerome V. Ciullo, MD, Detroit
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Perry W. Greene, Jr., MD, Grand Rapids
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Russell Miller, Consultant, Ann Arbor
Vern L. Norris, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

COMMITTEE ON WAYS AND MEANS

This Committee furnishes cost estimates to the House of Delegates on resolutions requiring new expenditures of funds. It also reviews general fiscal policies of the Society and makes recommendations re member dues.

Fred W. Whitehouse, MD, Chairman, Detroit
T. Calvin Blair, MD, Lansing
Arnold L. Brown, MD, Pontiac
R. Jack Chase, MD, Grand Rapids
Roy S. Hazen, MD, Northville
Richard M. Campau, Staff Assistant

TASK FORCE TO IDENTIFY GRANT PROPOSALS TO BE SUBMITTED TO THE MICHIGAN HEALTH CARE EDUCATION AND RESEARCH FOUNDATION

Leland E. Holly, II, MD, Chairman, Muskegon
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Fred E. Patterson, MD, Ann Arbor
Richard L. Rapport, MD, Flint
Charles C. Vincent, MD, Detroit
Frank B. Walker, MD, Grosse Pte. Farms
William G. Anderson, DO, Consultant, Detroit
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Frank J. McDevitt, DO, Consultant, Livonia

TASK FORCE ON CONCERNS OF FOREIGN MEDICAL GRADUATES

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Pramilla Sinha, MD, Southfield
A. L. Suarez-Martinez, MD, Dearborn
Wayne E. Burmeister, Staff Assistant

MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

January 22, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 19-20, 1986 — MSMS Maternal Health Conference, "25 Years of Growth and Change," Hyatt-Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

March 19, 1986 — MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

April 11-13, 1986 — AMA's Seventh National Conference on the Impaired Physician, Hilton Hotel and Towers in Chicago, contact: Pat Clark, (312)645-4497.

May 2-3, 1986 — MSMS House of Delegates, Hyatt Regency Dearborn, contact: William Madigan (517)337-1351.

July 17-20, 1986 — MSMS Midsummer Board meeting, St. Clair Inn, St. Clair, contact: William Madigan (517)337-1351.

OTHER MEETINGS

March 19-22 — 1986 Great Lakes Athletic Trainers Associations Winter Meeting and Sports Medicine Symposium, Amway Grand Plaza Hotel, Grand Rapids, contact: Lee Kermode, 2317 Gleneagle Drive, Kalamazoo 49001.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: February 12, Pediatric Neurology. Location: St.John Hospital, Detroit. **Sponsor:** St. John Hospital. **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: February 26 (plus five once-a-week sessions March 5,12,19,26,), Chemical Dependency. Location: Detroit. **Sponsor:** Fairlane Health Services Corp. **Contact:** Elaine Hughes, Fairlane Health Services Corp., One Parklane Blvd. Suite 1002-West, Dearborn 48126 (313)271-6502. **Approved for:** 3 hours of Category I Credit.

Date: March 12, Dermatology for Primary Care Physicians. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Approved for:** 8 hours of Category I Credit.

Date: April 7-9, Hemodynamic Monitoring and Management. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14.25 hours of Category I Credit.

Date: April 10-11, Mechanical Ventilatory Support and Management. Sponsor: University of Michigan Medical School. **Contact:** Dove Margenau, Towsley Center-Box 057, Ann Arbor 48109 (313)763-1400. **Approved for:** 14 hours of Category I Credit.

Date: April 16, Psych/Med Day. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital **Contact:** Carol Mastroianni, Program Coordinator (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: January 26-31, Tenth Annual Midwinter Family Practice Update. Location: Hilton Shanty Creek, Bellaire. **Contact:** Jolene Glasple, Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010 (313)763-1400. **Approved for** 20 hours of Category I Credit.

Date: April 23, Cancer Prevention and Early Detection. Location: Genevieve U. & Donald S. Gilmore Center for Health Education, Healthcare Plaza, Kalamazoo. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001. **Approved for** 6 hours of Category I Credit.

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"Onward to Lansing" Rally — October 22, 1985

Professional liability crisi

GENERAL AVIATION, INC.

It is a pleasure to welcome each one of you to this important meeting — the culmination of an immense amount of planning by Wayne County and the MSMS Hospital Medical Staff Section. The goal of our efforts today is to bring to the attention of our leaders in state government the terrible problems facing both patients and professionals which are based on outdated professional liability laws.

You are needed to help clarify the problem and our proposed solutions — and to urge legislators to take progressive steps.

Carl A. Gagliardi, MD
Chairman
MSMS Board of Directors

The problem of professional liability has created a long and ongoing battle. It is one which we must win for the benefit of the people and our profession.

In the year since I have been chairman of the Task Force, I have seen advancement and improvement. Our legislative package has concentrated its goals from those identified in 67 ideas into eight proposals. Remember that in addition to tort reform, we have six other areas of activities. Presently, the legislative action is of paramount importance.

Some legislators already have suggested that this rally is a pressure tactic and that they are accustomed to such pressure. It is true that they can resist pressure. Part of our job is to let them understand that this rally is not to exert pressure but to provide facts about how serious the situation is; that the people of the state already are suffering because of unnecessary costs and inaccessability to medical attention.

"Reasonable assertiveness" must be the order of our presentation.

Louis R. Zako, MD
Chairman
MSMS Special Task Force on Professional Liability and
MSMS Immediate Past President

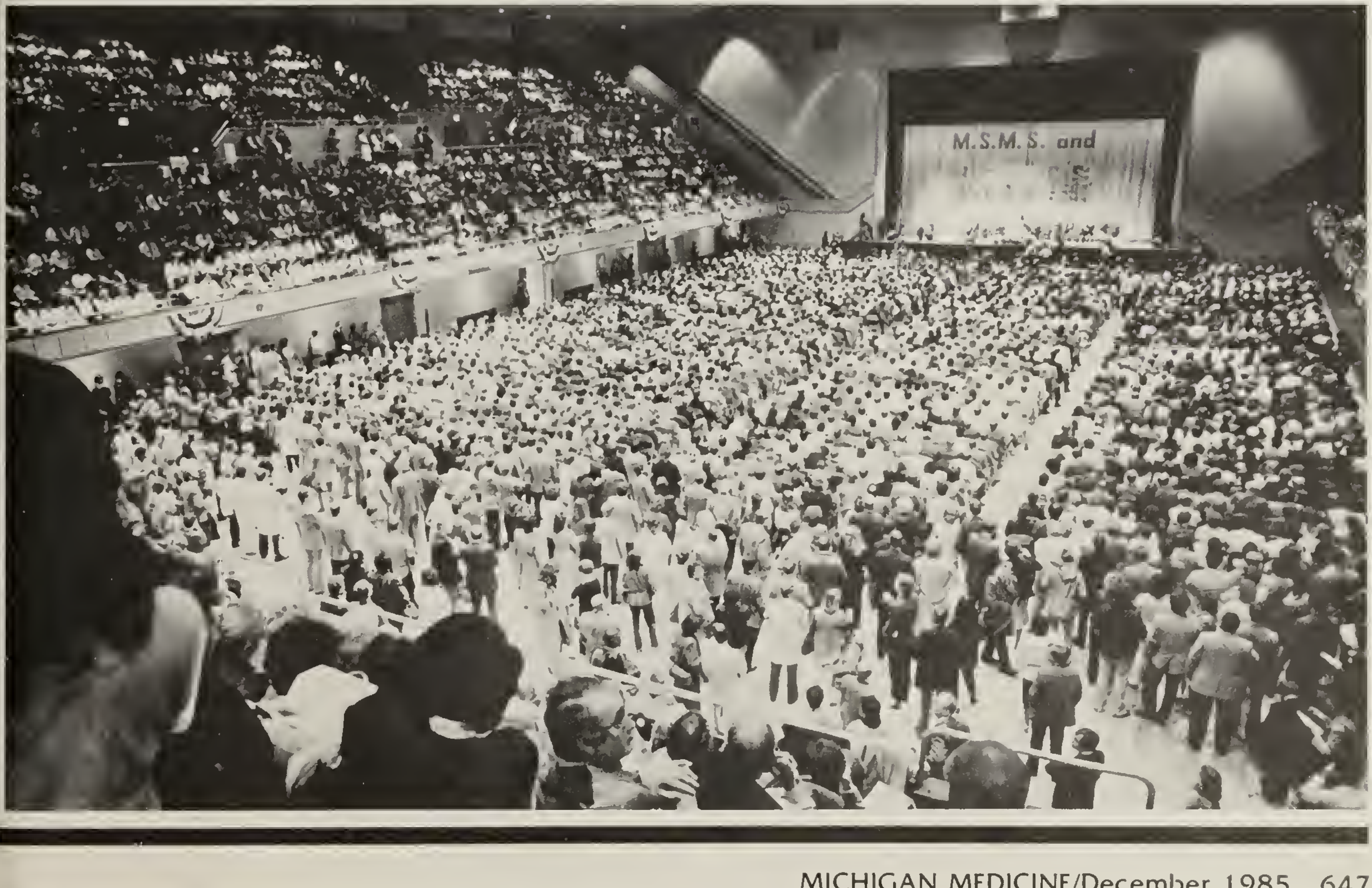
raws 12,000 to Lansing

Difficult situations require much thought and effort if they are to be improved. Certainly the professional liability situation is very difficult. Therefore I am pleased that so many of you are here. MSMS has had the benefit of your thoughts, and now we are going into action.

It is important to stress that what we advocate does provide justice for anyone who is damaged. It does so in a framework that permits physicians to provide medical care that people need.

Congratulations for your presence here, now let us take our issue and solutions to our lawmakers.

Thomas R. Berglund, MD
MSMS President-elect and
AMPAC Chairman



What an amazing assemblage! I've never seen 10,000 physicians in the same room before, to say nothing of the fact you are all here united for one reason, one dedication, one purpose: to convince legislators that we can no longer provide care to our patients, that our profession is being destroyed by defects in the law and those who take advantage of them. Your cause is just, and you are to be congratulated for this action. We at the American Medical Association salute you and wish you well. Your presence here today should be a strong indication of your support for the legislative action recommended by your representatives. Your actions and discussions should remain rational and factual because emotionalism has no role in settling such important matters.

James S. Todd, MD
Senior Deputy Executive
Vice President
American Medical Association

Order your *color* Rally photos on page 631.

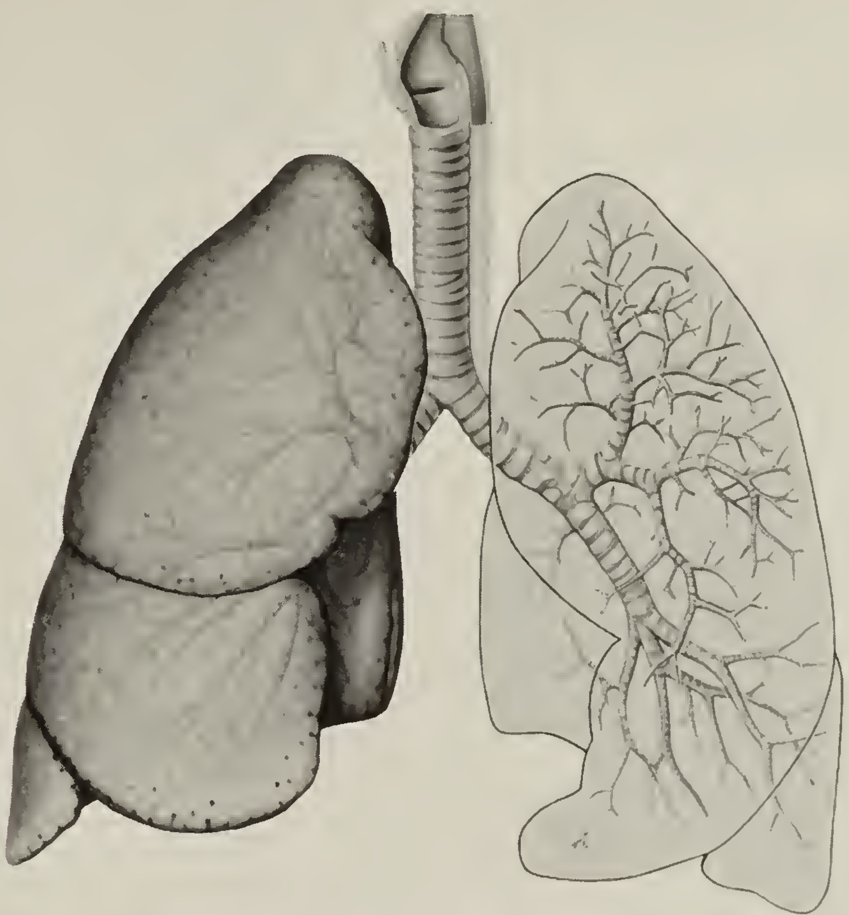
Because of the present tort system, many other groups are affected by the liability situation. This includes manufacturers, retailers, bar-owners, and even units of government. All of us, I believe, agree that those who suffer unjustly should be compensated. The goal is to do this wihout 50 percent to 70 percent of settlement funds going for expenses, legal fees and court costs. The public is paying unnecessarily. This means wasted dollars, inconvenience and even putting up with court dockets which are cluttered with liability cases which could be settled more efficiently under new law.

Bills to improve the situation are now before the legislature, so today we assemble here in a massive show of support for favorable action.

Peter A. Duhamel, MD
Chairman
MSMS Hospital Medical
Staff Section

VICE - CHAIRMAN
PUBLIC HEALTH
CORPORATIONS & FINANCE
TRANSPORTATION
LIQUOR CONTROL
EXIT

Consider the causative organisms…



Ceclor® cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out.

Precautions: *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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Additional information available to the profession on request from
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On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.)* The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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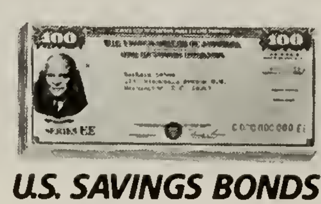

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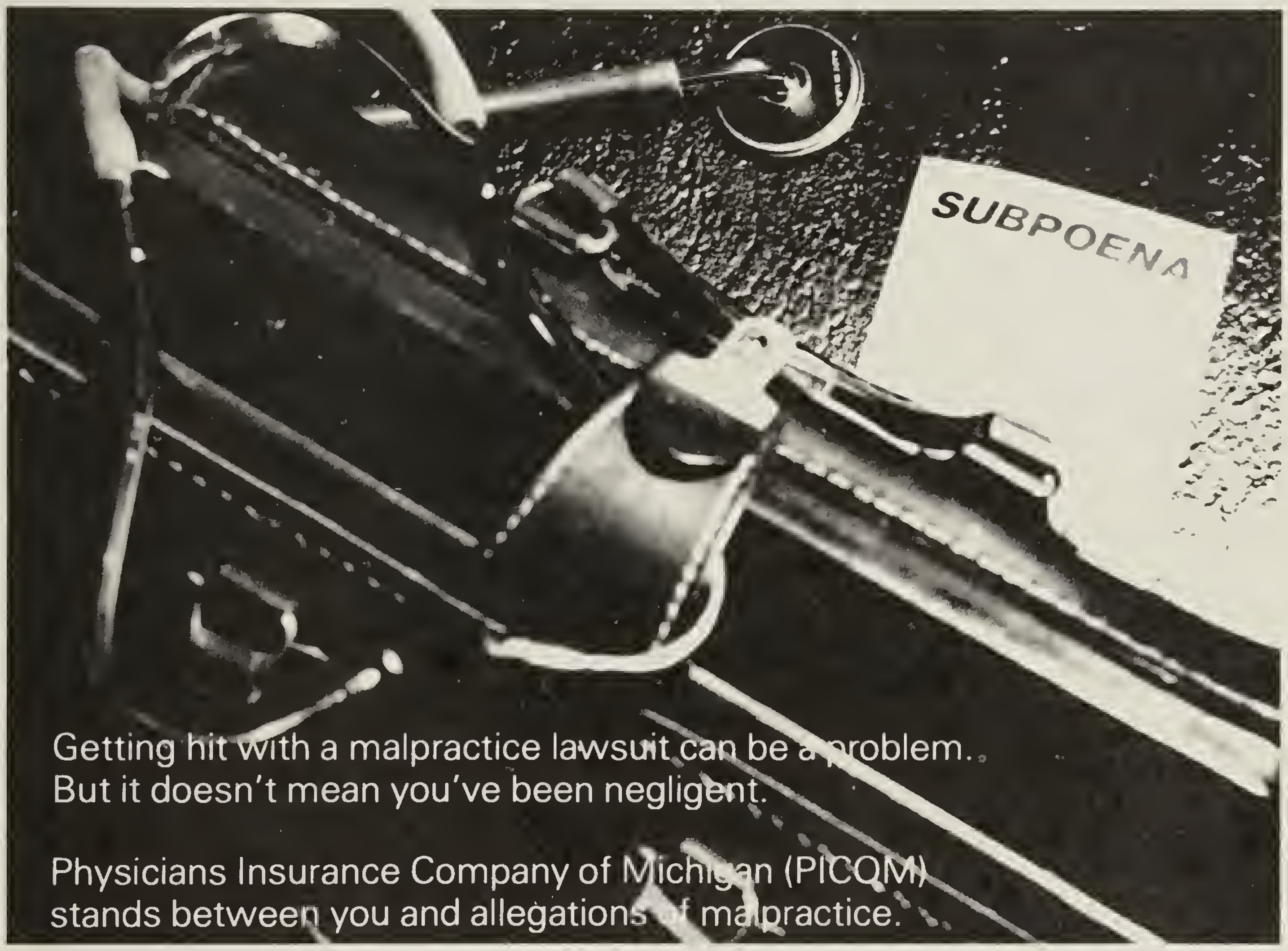

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By Ellen Vinocur Potas

New MSMS subsidiary markets computers for the medical office

Professional Computer Management, Inc. (PCM) is a newly-established subsidiary corporation of MSMS' Physician Service Group,Inc. PCM is marketing computer hardware and software to manage the professional office. The software package is called TIPS (Total Information for Professionals System).

For many years, PSG has evaluated the physician practice and recommended for or against computerization of the office. After reviewing many of the computerized systems on the market, the Michigan State Medical Society became aware of the TIPS program. We believe that the TIPS software package embodies some of the most advanced technology available today for the medical office.

The TIPS system runs on various types of computer hardware including IBM, AT&T, TeleVideo, Compaq and Tandy or any other machine using the standardized MS-DOS operating machines. Hardware systems have expandable capacity both in storage as well as adding more terminals to be located either within or outside the primary office. The system has remote access capability including the ability to turn the main computer on or off from a remote site.

Not just billing

PCM is not just a computer billing company; we sell more than computers. PCM personnel will analyze your computer needs and design a configuration that best suits those needs. We know the computer is a tool and not a comprehensive solution to all the problems and challenges facing private practices today. That is why we show you how to take full advantage of all the information that the computer can generate.

When a patient is first registered on the system, his/her basic demographic data is gathered. During each visit, the procedures performed, diagnosis or reason for the visit and appropriate charges are posted to the patient record. The system includes automatic preparation of statements and insurance claims. A total recall capability is provided so the physician has each patient profile under control — for preventive medical techniques, statistical comparisons, planning, clinical analysis and for sensitive billing problems. The system assists in managing the office functions by generating credit and collection reports, practice profiles indicating the number of procedures performed and accurate financial information.

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1. Interactive Charge and Payment Entry which immediately updates patient billing files. Registration and billing can be set up individually or grouped under a single guarantor.
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4. Complete Insurance Forms can be generated daily, weekly, monthly or on demand. Forms are printed either individually or in batch mode.
5. Audit Trails of financial information can be reported daily, weekly, monthly or on demand. These reports include:
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---

Ms. Potash is General Manager, Professional Computer Management, Inc.

charges by profit center, provider and location.

b. Daysheet — reports all charges, payments, write-offs, refunds and balances by patient.

c. Detailed Daysheet — lists by patient, debits and credits and accounting categories to which they have been posted.

d. Daysheet Summary — totals by accounting category for a user-specified time range.

e. Income Statement — complete statement showing sources of revenues and expense disbursements by accounting category.

f. Balance Sheet — detailed balance sheet of assets and liabilities.

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PCM believes that it offers state-of-the-art technology at a price that the physician's office can afford. For further information contact Ellen Vinocur Potash at MSMS headquarters, (517)337-1351.☐

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The brochure is the project of the MSMS Subcommittee on Public Service of the MSMS Advisory Committee on Communications and Professional Relations. Subcommittee chairperson is Susan E. Adelman, MD, Detroit.

Order your supply of brochures today by filling out the form below, or by telephoning the MSMS Department of Communications and Professional Relations, 517/337-1351.

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By Patricia W. Allen

Auxiliary is the physician's greatest ally

> **"An organization is not like a machine that is created at some point in time and then maintained with a minimum of effort . . . it is being continuously recreated for good or ill, by its members. This will strike some as a burdensome responsibility, but it will summon others to greatness."**
> **— John Gardner**

The MSMS Auxiliary, has reached a crossroads with the opportunity to move in one of two ways: toward increasing its membership and community impact, or toward rejecting new ideas because of lack of manpower to carry out programs.

This challenge comes at a time when the Auxiliary can do more for the image of medicine than almost anyone else. Why? Because Auxilians care the most. The Auxiliary is the physician's greatest ally and as such is a real public relations entity.

Is your spouse a member? MSMS/A cannot make the impact on communities and legislators without the support of more members. Even if spouses do not have time for active support they can demonstrate their concern for medicine in Michigan by joining MSMS/A. Those willing and able to give more time can do so, with assurance, there is unity in our ranks.

Commitment to medicine

Remind your spouse that MSMS/A is an elitist organization — not based on social status, economic class or accident of marriage — but based upon commitment to the health and well being of the people and to the medical profession. Auxilians should preserve and cherish this image.

This is no time to fragment. The price of everything is going up—even freedom. Could medical spouses spend their money more soundly than to add their voice and concerns to the efforts to project a positive public image of physicians at a time when everyone else is trying to portray them as self-serving? ☐

Mrs. Allen is MSMS/A membership chairman.

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By Michael J. Miller, M

Detroit Physicians for Social Responsibility reflect on the Nobel Peace Prize

The Detroit Chapter of Physicians for Social Responsibility was excited and honored to learn of the awarding of the 1985 Nobel Peace Prize to their parent organization, International Physicians for the Prevention of Nuclear War (IPPNW).

The award was announced in Geneva October 11, where the two co-founders, Doctor Bernard Lown, representing the United States, and Doctor Yevgeny Chazov, of the Soviet Union, were celebrating their organization's fifth anniversary.

The award is particularly timely in view of the recent summit meeting between President Reagan and Soviet leader Gorbachev. The presentation of this most prestigious of Nobel Prizes to a group of physicians signifies the critical importance of our cause. The organization has grown from a mere six members in 1980 to a worldwide network of physicians' groups now totaling approximately 140,000 members in over 40 countries, including 40,000 in the US and 60,000 in the USSR.

The current major effort of IPPNW is to encourage the US to join in the moratorium on further testing of nuclear weapons announced by the Soviet Union on August 6, 1985, extending at least until the end of this year. The hope is that by doing this, momentum will build toward the signing of a Comprehensive Test Ban Treaty (CTBT), which actually is 90 percent agreed upon already. This is an essential first step for achieving the "Medical Prescription" prescribed by

Continued on page 664

Doctor Miller is an active member of Detroit Physicians for Social Responsibility.

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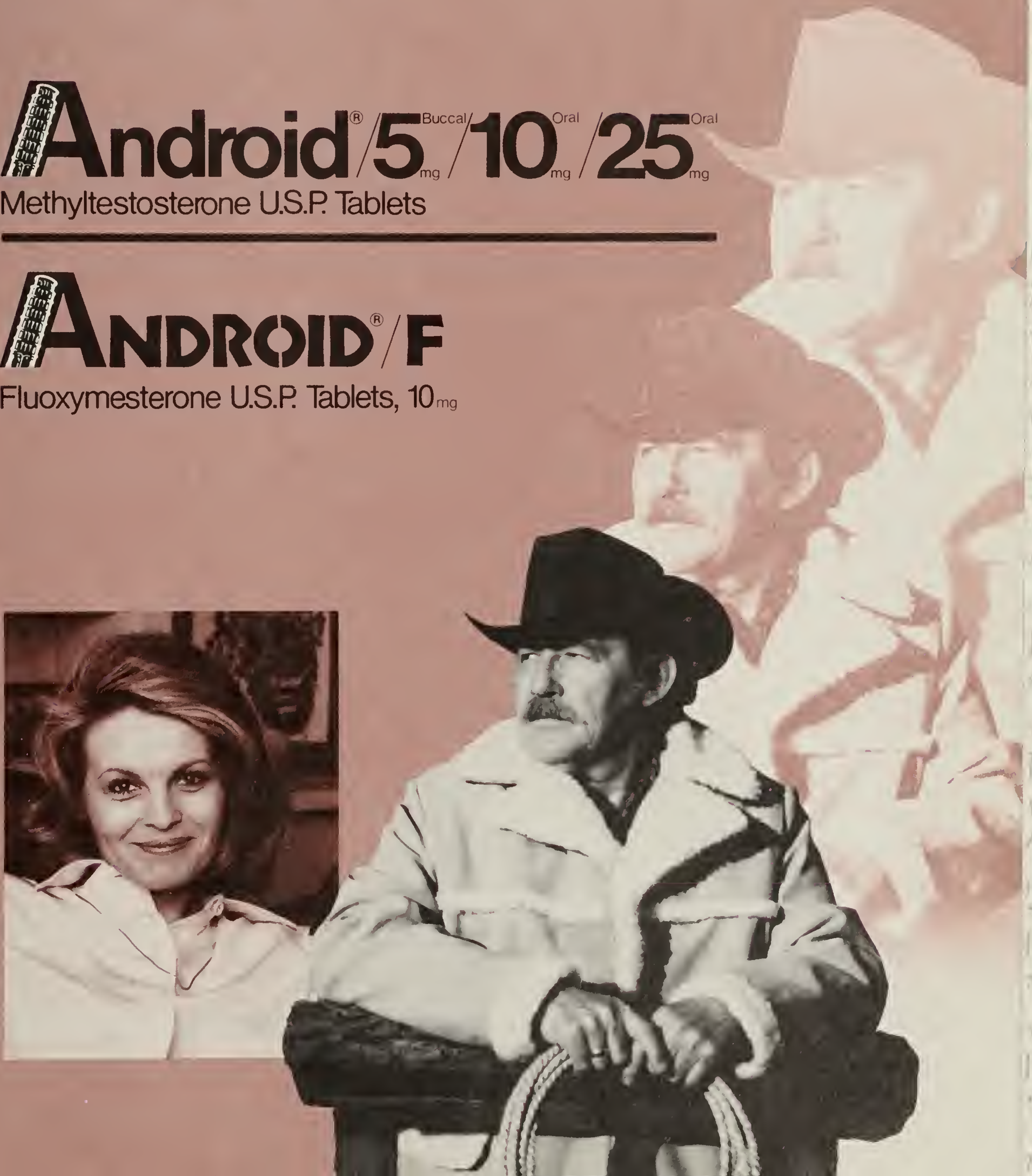

IPPNW for prevention of nuclear war.

Star Wars opposition

In addition to favoring a CTBT, IPPNW is opposed to further development of plans for the Strategic Defense Initiative (Star Wars) program because: (1) SDI cannot protect the population from a full-scale nuclear attack or nuclear terrorism. (2) Defensive systems can be easily overcome. (3) The system would have to work virtually 100 percent perfectly the first time. (4) SDI is destabilizing because its pursuit increases the threat of nuclear war and undermines prospects for arms reductions. (5) SDI is prohibitively expensive, with some estimates running as high as a future cost of $1 trillion.

As an example of how these limited resources could better be spent, IPPNW is initiating a program to inocculate the world's children against childhood diseases such as measles, polio and tetanus, which now claim the lives of some five million children yearly. This can be accomplished for little more than the cost of a single B-1 bomber, as was the case with eradication of smallpox from the face of the earth by the World Health Organization.

Human history is literally at a crossroads, as we may never again have this unique "window of opportunity" to begin reversing the vicious disease cycle of testing-building-deploying at each new phase of the arms race. As Doctor Lown has warned, "If the United States continues with its current rate of arms buildup, you will not see the year 2000." It is tempting to believe that a technological fix will "cure" the disease of nuclear war. However, weapons are the disease; they are not part of the cure. There is no cure, only prevention.

I urge you to join with thousands of your colleagues now in every part of the world by doing the following: Join your local affiliate of IPPNW (PSR-Detroit (313)577-3168) in order to strengthen our influence. Just as our collective presence was felt on the malpractrice issue in Lansing, so can our collective voices be heard in Washington, DC. Write a letter, or send a telegram to President Reagan expressing your support for a mutual moratorium and signing of a CTBT, with copies to your Congressional representatives. Your voice as a physician will be heard and respected by your elected representatives. As Doctor Lown stated recently, "We must make peace through medicine, and in the process compell our political leaders to remove the threat of nuclear war."☐

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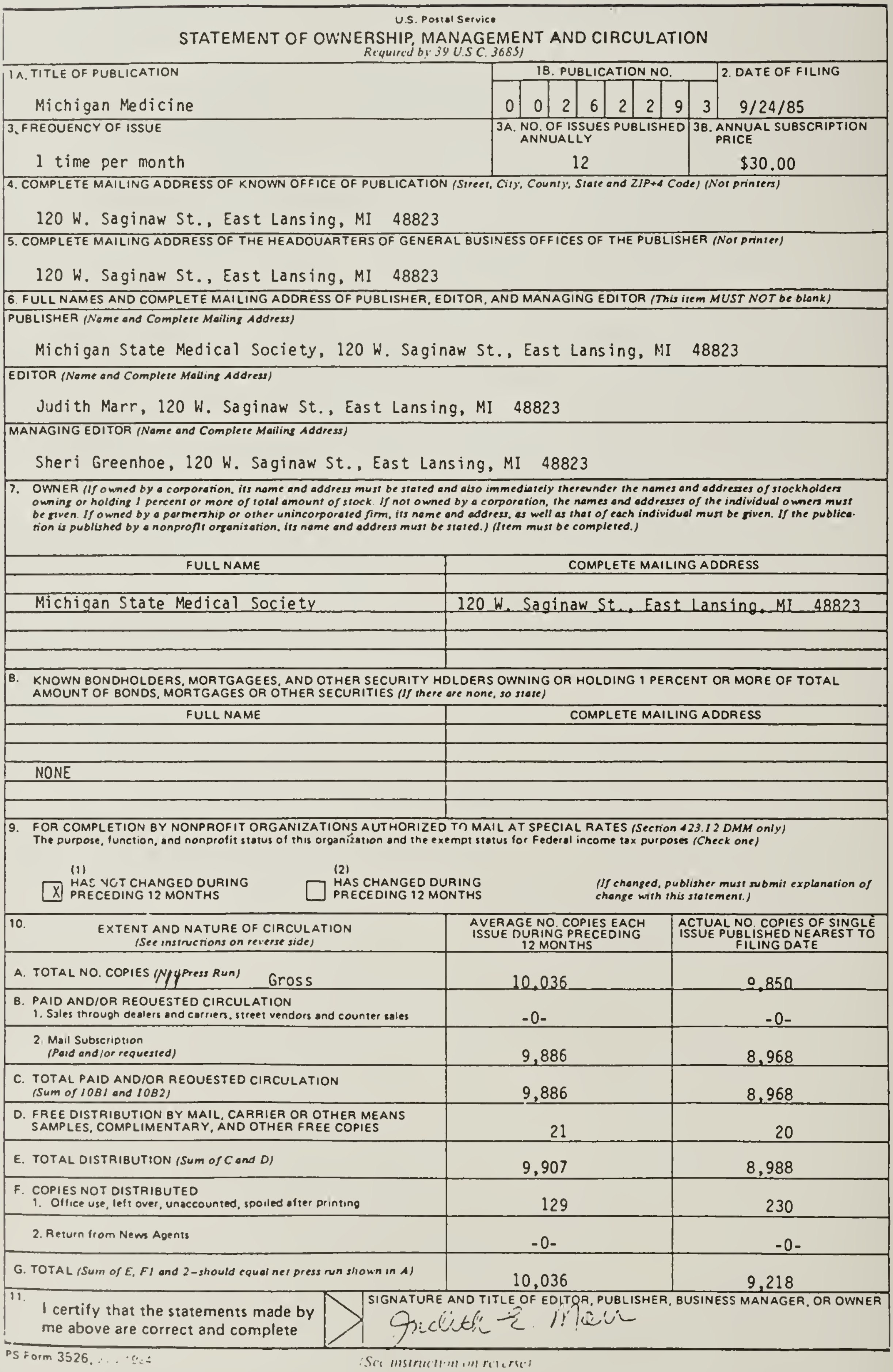

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Radiology news awards

The American College of Radiology, in association with the Radiological Society of North America and the American Roentgen Ray Society, is pleased to announce the competition for the 1985 Radiology News Awards.

For the last six years, awards have been made for original stories on the use of radiology in diagnosing and treating human disease. Prizes of $500 to $1,000 are given in three major categories: General publications: newspapers, science news publications for a general readership, wire services and news magazines; Medical science publications: stories written by laymen for physicians and scientists; Broadcast media: radio or television news reports and features.

Judges in the contest are leading physicians and scientists in the field of radiology and practicing journalism professionals. Entries are judged on the basis of originality, objectivity, clarity, scientific accuracy, original research and excellence in production.

The following criteria for entering this competition applies: Entries must have been published or broadcast during 1985; All entries must be postmarked by February 28, 1986; Submission may be of a single story or broadcast, or a series of stories; Stories should be about the use of imaging devices and radiation to diagnose or treat disease. Submissions on new technology in the field of radiology and new applications for conventional radiology are welcome, as are submissions that discuss delivery of care and other issues of practice economics in radiology; A completed entry blank must be submitted together with entry in originally published form. Video materials should be submitted in¾ inch cassettes. Include a brief outline of the contents and a script if available; Judges decisions are final. No entries will be returned.

If you are interested in participating in this competition, contact: Radiology News Awards, The American College of Radiology, 1891 Preston White Drive, Reston, Virginia, 22091 or (703)648-8900.

Pew Doctoral Program seeks applicants

The Pew Doctoral Program in Health Policy at the University of Michigan's School of Public Health is now accepting applications for the session beginning in Fall, 1986. This three-year, non-residential doctoral program permits successful health care practitioners, who have prior graduate education, to pursue the Dr.P.H. degree at monthly four-day weekend seesions at the University of Michigan, while remaining employed full time.

Administered jointly by the Departments of Hospital Administration and Medical Care Organization in the University of Michigan's School of Public Health, the Pew Doctoral Program was established in fall, 1984, with funding from the Pew Memorial Trust. It was created to encourage the dialogue between scholar and practitioner and to address the concrete concerns of policymakers with advanced academic tools.

The curriculum includes doctoral-level courses in: epidemiology, research and evaluation, health economics, health politics, organizational behavior, medical care organization, and legal issues in health policy, in addition to case-oriented seminars which apply interdisciplinary perspectives to policy issues.

Students in the program have had at least five years of professional health policy experience, as well as a previous graduate degree. The professional backgounds of the current class include hospital administration, as well as health management, policy analysis, consulting, research, planning and financing at the local, state, and federal levels.

For more information write to: David Perlman, M.P.H., Progam Manager, The Pew Doctoral Program in Health Policy, M3031 School of Public Health II, U-M, Ann Arbor, MI, 48109-2029.

Gerontology Scholar-In-Residence Award

The Center for Applied Gerontology and its sponsor, the Council for Jewish Elderly are now accepting nominations for the 1986 Scholar-In-Residence Lectureship and Award, a foot-and-a-half bronze sculpture titled "Heritage."

As Scholar-in-Residence, the winning nominee is expected to give an original, publishable paper to a professional audience in Chicago on May 14, 1986. The presentation must be on an aspect of gerontological practice within the individual's primary discipline.

Please submit your nomination in the form of a letter, giving reasons for your recommendation. Included should be two additional letters of endorsement and the candidate's curriculum vitae.

Please submit seven (7) copies of these materials to: Academic Advisory Committee, Center for Applied Gerontology, 7457 North Western Avenue, Chicago, Illinois 60645. To be considered, nominations must be postmarked no later than January 4, 1986.

Continued on page 670

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New drug for treating narcotic addiction

"A decade from now, a large group of former narcotic addicts will say they never would have been able to conquer their problem without Naltrexone."

So says psychiatrist and chemical dependence expert Richard Morin, MD, Medical Director of the Nelso J. Bradley Mental Health Center, a specialized 75-bed unit of Detroit's Samaritan Health Center. Morin heads Bradley's Naltrexone Treatment Program, which was initiated shortly after the Food and Drug Administration approved the new drug last November.

"Naltrexone is the newest way to treat narcotic addiction," Morin explained. "It blocks the user's 'high' and prevents physical dependence from chronic drug use. It allows the patient to lead a normal life while undergoing therapy because it is neither mind-altering nor addictive, unlike conventional treatments, such as those based on methadone.

Patients treated for narcotic addiction at the Bradley Center spend seven to 14 days being "detoxified," a process that involves waiting for all drugs to leave the body while providing medication for withdrawal symptoms, which may include chills, fever, nausea and vomiting. If patients select the Naltrexone Therapy Program, which is strictly voluntary, drug-free status is established at the end of detoxification through the "Narcan Challenge." The drug Narcan causes instant withdrawl symptoms if any traces of narcotics remain in the system.

"Although a three-week inpatient program of education, lectures, and extensive therapy is recommended, drug-free patients can be discharged on Naltrexone, with therapy continuing on an outpatient basis," Morin said.

Harper Hospital announces new magnetic resonance center

Harper Hospital announced recently the construction of a center for magnetic resonance imaging. When completed in the fall of 1986, the complex will house three magnetic resonance imaging (MRI) devices. Two will be dedicated to research while the other will be used in diagnosing patients' diseases and to monitor the progress of their treatments.

The MRC will be the first clinical and research center of its type in Michigan and one of only a dozen such facilities in the nation.

U-M Medical Center opens osteoporosis test center

The University of Michigan Medical Center has opened an Osteoporosis Test Center to provide a new, painless and simple test to detect osteoporosis. According to Brahm Shapiro, MD, PhD, associate professor of internal medicine in the Division of Nuclear Medicine at the U-M Medical School and coordinator of the U-M Osteoporosis Test Center in University Hospital, "As many as one in four white American women over 65 may suffer from osteoporosis with enough severity to result in bone fractures."

"We are offering the new test for people who already have osteoporosis to help them manage their disease, and to screen those who are at high risk," Doctor Shapiro said.

The test, called dual photon absorptiometry, is painless, takes about 45 minutes and requires only that heavy clothing be removed.

U-M researchers find mammography underused

Mammography, the most effective method for the early detection of breast cancer in women over 35, is widely underused by physicians and patients instead of becoming a preferred mass screening techique, according to researchers at the University of Michigan Medical Center.

Two other breast cancer screening methods—breast self-examination and clinical examination by a physician—are performed more frequently than mammography but are also underused to some extent, the U-M researchers found.

Writing in the September issue of *Radiology*, published by the Radiological Society of North America (RSNA), the U-M researchers called for radiologists to encourage family physicians and other health care practitioners to launch a massive education effort to convince more female patients of the importance of mammography in a lifelong program of breast cancer screening.

"One explanation for the underuse of mammography by physicians," said Sara Fox, MD, one of the U-M researchers, "is that the majority of referrals appear to be made for the purpose of diagnosing the disease (after symptoms have been detected)."

The U-M researchers said that specifying mammography only for women who have symptoms of breast cancer and not for screening women without apparent clinical signs tends to greatly restrict use of this highly effective detection method. ☐

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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
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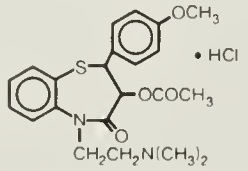
DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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ohn G. Beall, MD
raverse City
octor Beall died October 4. He graduated from Loyola University in Illinois in 1940 with a degree in ophthalmology. Doctor Beall had been a resident of Traverse City since 1945.

alph Hagar, MD
Wyoming
octor Hagar died September 2. He was a 1933 graduate of he University of Michigan Medical School and was affiliated with St. Mary's and Zeeland Community hospi- als.

Frank King, Jr., MD
Benton Harbor
Doctor King died October 8 at the age of 76. He received his MD degree from the University of Michigan Medical School in 1934 in surgery and practiced medicine in Benton Harbor for nearly 50 years.

Stanley Sciarrino, MD
Southfield
Doctor Sciarrino died October 16 at the age of 89. He graduated from St. Louis University of Medicine in 1922 and was on staff at the Grace Hospital Northwest branch in Detroit.

Walter M. Whitehouse, MD
Ann Arbor
Doctor Whitehouse died October 9. He was a graduate of the University of Michigan Medical School where he received his MD degree in radiology in 1941. He was a professor with the University Hospital in Ann Arbor.

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PHYSICIAN PRECEPTOR IN PEDIATRICS — Upper Peninsula Health Education Corporation is accepting applications for a full-time physician preceptor in pediatrics. Responsibilities include patient care and clinical instruction of medical students of Upper Peninsula branch campus of Michigan State University's College of Human Medicine. Requirements are board eligibility or certification in pediatrics with a commitment to medical education. Academic rank and salary commensurate with experience. Send inquires to John Hickner, MD, Medical Director, Bay de Noc Family Health Center, Doctors Park, Escanaba 49829 (906)786-9510.

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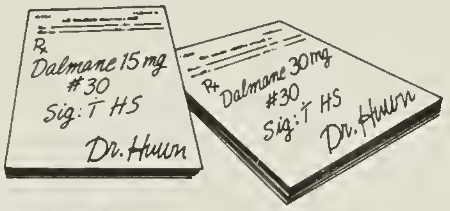

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